



The Independent Commission on Development and Health in India

Comparison of the Health Sector in India, Indonesia & Thailand: Policy Prescription for India



About the author

Javid A. Chowdhury is a retired officer of the Indian Administrative Service. After completing his M.Sc. (Physics) from St. Stephen's College, Delhi, he joined the IAS in 1965. In his career spanning nearly four decades, he has acquired vast experience in developmental administration at the field level, and also in policy formulation and macro-planning at the level of the State and Central Secretariats.

In the Union Government he has served, at different times, as Secretary in the Departments of Food, Revenue and Health. He was a member of the Executive Board of the World Health Organisation for a period of three years and was elected as Vice-Chairman of the Board. He has also served as a Consultant to the World Health Organisation's Regional Office for South-East Asia. He has a deep interest in the study of the social sectors, particularly the Health Sector.

Currently he is engaged in researching various facets of the Health System in India.

Community Health Cell

Library and Information Centre

367, "Srinivasa Nilaya"
Jakkasandra 1st Main,
1st Block, Koramangala,
BANGALORE - 560 034.

Phone : 553 15 18 / 552 53 72

e-mail : chc@sochara.org

Comparison of the Health Sector in India, Indonesia and Thailand : Policy Prescription for India

COMMUNITY HEALTH CELL

Library and Information Centre

No. 367, Srinivasa Nilaya, Jakkasandra,
I Main, I Block, Koramangala, Bangalore - 560 034.

THIS BOOK MUST BE RETURNED BY
THE DATE LAST STAMPED

--	--	--

1109
14/2/06

Independent

h in India

Author

Javid A. Chowdhury

Copy Editor

Vijaya Ghosh

Coordinator

Suzanne Van Hulle

Design & Pagelayout

Brajagopal Paul

Subhash Bhaskar

Production

Health Promotion & Development Communications

Printed at

VHAI Press

ISBN: 81-88973-93-9



© **Voluntary Health Association of India, 2006**

B-40, Qutab Institutional Area, South of I.I.T.,

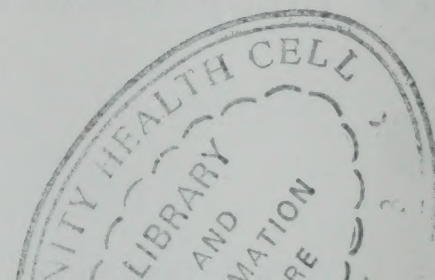
New Delhi - 110 016.

Reproduction, adaptation and translation is authorised worldwide for non-profit educational activities and publications, provided that the permission is obtained from the publisher and copies containing reproduced material are sent to: The Chief Executive, VHAI

HP-120

09228

1206



Preface

Fortunately, during recent times, Public Health has received renewed focus from important global organizations such as the United Nations, G-8 countries, and through the formation of the Macroeconomic Commission on Health, along with several national initiatives of different countries. This is a welcome development particularly keeping in view epidemiological transitions, and the current understanding that economic prosperity of a nation can only be sustained if it has a sound public health infrastructure. Coping with emerging new diseases, re-emergence of old diseases and life-style related health problems, poses a major challenge for the future. Asia will have the largest burden of this major agenda.

Countries within the region have much in common regarding the problems the societies confront, as well as extensive government health infrastructure, which is unfortunately mired by centralized planning, inadequate resource allocation, under-utilized facilities, and of course limited involvement of its people. Therefore, progress of countries within the region has been mixed.

In the past, there has not been a systematic effort to document the experiences of health sector reforms in the countries of Asia, which can lead to a mutual learning process. In this context, this monograph is an important effort. India, Indonesia and Thailand are very important countries within Asia, as well as globally. Understanding the evolution of their health policies can have valuable lessons, not only for other developing countries, but also for developed countries. It is sad to note that India's performance has remained much behind that of Indonesia and Thailand. Perhaps renewed focus of the present government on revamping the health infrastructure would improve the situation.

Shri Javid Chowdhury is an able and competent health administrator. His contribution to the formulation of India's National Health Policy is well known. Shri Chowdhury had the opportunity, provided by WHO, to look at various dimensions of the health sector in India, Indonesia and Thailand. His analysis of this understanding will benefit all concerned. The publication will be an important learning tool for health professionals.

Alok Mukhopadhyay
Convenor

Acknowledgements

I had the opportunity of working as a Consultant in the World Health Organisation's Regional Office for South-East Asia for one year in 2002-03. During that period I researched the Health Systems of Indonesia, Thailand and India. In the course of the Consultancy I was beneficially introduced to a wide range of documents and literature relating to the Health Systems of these three countries. The principal documents are listed as references in this monograph. Some of the ideas that came to be planted in my mind in the course of the Consultancy have matured over time and become the basis of this monograph. In this background, I would like to take this opportunity to thank the World Health Organisation for introducing me to this area of study. Needless to say, the entire responsibility for the views expressed in this monograph is mine.

I would also like to use this opportunity to thank the Independent Commission on Health in India, and also Alok Mukhopadhyay, Chief Executive, VHAI, for agreeing to publish this monograph at short notice.

Javid A. Chowdhury

New Delhi, 8th December, 2005

Contents

Preface	iii
Acknowledgements	iv
I. Introduction	I
II. India	3
III. Indonesia	11
IV. Thailand	20
V. Comparative Analysis and a Prescription for the Indian Health System	27
VI. Conclusion	47
References	59
List of Abbreviations	62

I. Introduction

India, Indonesia and Thailand are developing countries of Southeast Asia at three distinct stages of economic development. Their per capita GDP (US\$ - year 2002) is respectively 487, 817 and 2060. The first country stands low down in the low-income group, while the second and the third belong to the middle-income group. All three countries have existing health systems significantly deficient in several components for achieving the national health goals. These countries have over the last decade or so been struggling with their plans and strategies to reshape their system in order to improve its performance, while simultaneously ensuring its sustainability in the fast changing global economic scenario. The process of transformation of the systems in these three countries is currently poised at different stages, and the current health attainment is also at staggered levels. Over the last two decades, countries the world-over has been engaged in what, in generic terms, is known as 'reforms'. This was largely the reactive impulse of individual countries to the compulsions of the sweep of economic globalization and domestic liberalization. In the package of initiatives undertaken in the domestic health sector of individual countries, 'reforms' have, inter alia, come to acquire the following main features: increased private sector share in national health services; systematic decentralization of powers of budgeting as also the authority for discharge of functions in the public health organizations; grant of increasing autonomy in the operation of public health service centres; a search for new mechanisms of healthcare financing; increasing introduction of user charges in public health service centres as a new form of healthcare financing; adoption of a variety of social health insurance packages with varied financing components and service delivery features; increased use of private health service centres funded through public resources; etc. The variety of evidence generated and the practical insights

from the operational feedback in one country, is of much value to other developing countries engaged in the process of restructuring and improving their health systems. The three countries compared in this monograph - India, Indonesia and Thailand - are each in their own way attempting to restructure their health systems. The present exercise of comparison of the efforts in the three countries is likely to be useful because these three countries represent graduated stages of the ongoing transformation of state-centric organisational structures inherited from an earlier age. Thailand has a well-endowed health system with a wide coverage of the population, backed by ample resources, both in the public health system and by way of private funding; Indonesia is an example of a grossly under-developed health system with limited coverage of the population, and with an untenably low allocation of resources for both public and private services; and, India represents a third typology with a huge disease burden, inadequate availability of services, and with an even more grossly inadequate public health component in the aggregate health services. The significant difference between the sub-standard health scenario in Indonesia and India, is that the former has at least completed much home-work by way of conceptual thinking and planning, for devising a strategy to attain their stated goal of universal health coverage; while, India on the other hand, struggles at an even more rudimentary conceptual level. The approach adopted by Indonesia and Thailand in transforming their national health system in order to converge on their principle goal of universal health coverage, has identified several landmarks which could well be utilised by India too in charting its course; and, much of the database generated in Thailand in the course of their intensive research of the health system and the data relating to health economics of their country, would provide useful pointers as to the appropriate structure of pilot studies and other field experiments which may

have to be conducted in order to craft operational modules suited to the ground situation prevailing in India.

In the above backdrop, an attempt is made in this monograph to draw up a prescription for restructuring the health system of India based on the experience of Indonesia and Thailand. The monograph has been structured in six sections. Section I is Introductory. Sections II, III and IV respectively give an overview of the health scenario and the salient features of the health system in India, Indonesia and Thailand. Section V attempts a comparative analysis of those important features of the three countries that have a prescriptive significance for the health system; and from that identifies certain prescriptive conclusions that could be of use to India, a country that is only beginning its journey towards devising a healthcare system with universal coverage. Finally, Section VI sets out some analytical observations considered appropriate as a conclusion to the monograph.

It may be mentioned that the approach in this monograph is to compare the major features of the health systems in the three countries. In the course of this exercise many obstacles are encountered. Developing countries generally have

meagre and non-standardised databases. Even in the various studies published in a particular country, the presentation of statistics is found to be in a variety of formats. This raises problems in inter-country comparison. Such a handicap is particularly encountered in the case of India and Indonesia; in Thailand, with over two decades of systematic research in health systems, the formatting of data is much more standardized, and the quality is much more robust. Also, it is observed that developing countries release data long after the period covered, and the data is therefore dated. Here again, more difficulties are encountered in the case of India and Indonesia. In the case of Thailand, this author has relied on an unpublished document of a World Bank researcher who had direct access to the unreleased national health statistics of Thailand pertaining to recent years. While on this point, it may be mentioned that comparison of statistics dating to periods a few years apart for developing countries, is not likely to compromise the validity of the broad conclusions reached. The changes in the health sector are slow and are normally captured in the quantifiable health indicators after a gap of several years. In this situation, the gap of a few years in the statistics of different developing countries that are being compared, should be acceptable in an inter-country analysis.

India is categorized as a low-income, developing country. It has a gigantic population of 1027 million (Census: 2001). On account of its varied geographical and socio-economic features, India's health sector is characterised by a wide variation in the level of health indicators in different parts of the country. On the basis of the health status of the people, and the existing capacity of the health service delivery systems, the states within the country can be categorized in four main groups—in the group with the highest health standards are Kerala and Tamil Nadu, covering 9.1% of the population; and in the group with the lowest standards are Assam, Bihar and Jharkhand, covering 13.3% of the population. In between these come two groups of states containing the bulk of the population, with intermediate attainment levels of health standards. There is a wide variation between the basic health indicators in different parts of the country. For example, the IMR in Madhya Pradesh (85) and Orissa (87) is more than ten times higher than the IMR for Kerala (10). Similarly, there is pronounced disparity between Rural and Urban areas—in Andhra Pradesh the Rural IMR is 71 as compared to 35 in the Urban areas; and in Karnataka the Rural IMR is 65 as against 25 in the Urban area. Abnormal IMR differentials also exist between boys and girls in certain parts of the country—in Haryana, for instance, female IMR is 73 as against 54 for males. In the group of states with the highest health standards, Kerala would globally compare well with upper middle-income countries, such as Argentina, Venezuela, Mexico, Oman and Saudi Arabia. Most of the states in the country belonging to groups II and III would compare with lower middle-income countries of the globe; however, the group of states with the poorest health standards can only be globally compared to low-income countries like Ghana, Myanmar, Sudan and Nigeria. Also, even within a particular compact geographical area of the country, a wide variation in access to health care services

and level of health standards is observed on account of several factors—non-availability of purchasing power, with 26.1% of the population living below the poverty level (National Human Development Report, 2001—Planning Commission); uneven spatial spread of healthcare infrastructure in the states; and a disproportionate dependence on private healthcare services vis-a-vis public services.

Health Sector Expenditure

Currently, the total annual expenditure in the national health sector is of the order of 5.1% of the GDP, which compares favourably with the average of 5.6% in low and middle-income countries—it is higher than that in several prominent countries, such as Egypt, Malaysia, Philippines and Sri Lanka. In statistical terms, amongst the countries listed in the Human Development Report—2003 - out of 120 countries in the Low Human Development/ Medium Human Development categories, India's total health expenditure as a percentage of GDP, is higher than that in 72 countries. Taking a view of these facts it is clear that the total health expenditure in the country is not inordinately low. What, however, is a serious deficiency is that only 0.9% of GDP i.e. 17% (currently of the order of Rs. 200 per capita per year) is the public health component of the total health expenditure (National Health Policy—2002). The balance of 83% is the private expenditure component, most of which is in the nature of 'out-of-pocket' expenditure. The public health expenditure figure compares extremely unfavourably with an average public health spending of 2.8% of GDP for the low and middle - income countries of the globe, and 1.7% for even the impoverished Sub-Saharan countries. The national public health expenditure in monetary terms is of the order of US\$ 13 (on PPP basis). Such a public health outlay, at costs prevailing in the

developed world, would at best provide each citizen with two strips of branded analgesics! This deficiency has serious implications for the health security of the poor even in states like Kerala, where otherwise the health status of the citizens matches that in developed countries. The result of the low public spending is highlighted in a study that has shown that the health expenditure as a proportion of total expenditure, for the lowest quintile of the population, is typically lower than the average for all the quintiles in both rural and urban areas. In other words, the lower income groups are unable to gain equitable access to health services. The miniscule commitment to public health expenditure is an embarrassing feature of the Indian health scenario; there are only four countries of the globe that invest a lower percentage of their GDP as public expenditure in the health sector (Nigeria; Sudan; Indonesia and Myanmar - World Development Report-2004). In the matter of commitment of resources to this component of the social sector, India is in embarrassing global company.

Though under the Indian Constitution the subject-'Public health and sanitation; hospitals and dispensaries'-comes within the domain of the powers of the states, the central government has always chosen to make a significant contribution to the aggregate financial resources in the health sector. Currently, central expenditure constitutes about 25% of the total public health expenditure in the country. The central government expenditure, which had remained steady at 1.3% of the total central budget over the eighties and nineties, has latterly risen to 1.7% by year 2003-04. Through the instrumentality of the national five year plans, the central sector has shown a steadily increasing support to the health sector-3.11% of the aggregate outlay in the Seventh Plan to 4.17% of the aggregate outlay in the Tenth Plan-though, even this is inadequate looking to the rise in population in the period, as also considering the irreducible requirements of the national health system. Currently, 17% of the public health resources

come from international funding. Public health services are provided in the field largely through the state health organisational structure. The finances of most state governments are known to be severely strained and, in fact, state government funding of the health sector has reduced from 7% of the state budget in the mid-eighties to 5.5% in the late nineties. The total public health expenditure (Centre plus State) as a percentage of GDP has been stagnant over time. In this situation of declining state government allocations, the year-on-year incremental funding for public health, small though this is, has originated from the central budget.

The broad break-up of the public health expenditure in the country is also significant: Primary sector-42%; Secondary sector-34%; and Tertiary sector-24% (1998-99 statistics). Expenditure in the primary sector is most cost-effective and, therefore, most desirable for a resource-deficient country. What is even more disconcerting is that in the period between 1985-86 and 1998-99, public expenditure in the primary and secondary sector has increased by only 50% while that in the tertiary sector has increased by 100%. It is with this skewed expenditure in mind that the NHP 2002 has recommended the scaling up of the public expenditure in the primary sector to 55%.

Health Status

Though resources have always been inadequate, in the last five decades since independence, the Indian health scene has shown noteworthy improvement in representative health indicators: life expectancy - 54 to 65 (1981-2000), crude birth rate - 41 to 26 (1951-98), crude death rate - 25 to 9 (1951-98), total fertility rate - 6.6 to 2.9 (1960-97) and Infant Mortality Rate-146 to 72 (1951-97). But, these improved levels are still well below those prevailing in several other developing countries, as also way below minimum socially acceptable levels. The Indian

health scene still records very high levels of morbidity and mortality, much of which is easily preventable. India accounts for 20% of the total global disease burden. With a 17% share of the global population, at a disaggregated level, the country accounts for 23% of child deaths, 20% of maternal deaths, 30% of the TB cases, 68% of the Leprosy cases and 14% of the HIV infections. The broad break-up of the burden of disease for year 1998 is: Communicable diseases—50%; Non-communicable diseases—33%; and Injuries —17%. The projections for burden of disease by the year 2020, predict almost a reversal of the percentage figures for communicable and non-communicable diseases as compared to 1998 — the percentage figure for communicable diseases is expected to fall from 50% to 24%, while the non-communicable disease percentage figure is expected to rise from 33% to 57%.

Currently, India bears a disproportionate fraction of the global burden of the major communicable diseases—TB, Malaria, Leprosy, acute respiratory illness, diarrhoeal diseases and other vaccine preventable diseases. Order of magnitude figures for communicable diseases indicate 2.5 million child deaths and an equal 2.5 million adult deaths, in a year.

It has often been commented that India's adopted mode of economic development has resulted in a 'twin-track' economic growth for different sections of the population; and consequent to that, India (as also several other developing countries) displays conflicting features of a double-burden of disease. Along with the communicable diseases, which are often intrinsically associated with economic under-development, and are an unrelieved constant in our history, India now faces an increasing burden of non-communicable diseases (Diabetes, CVD, Asthma, Cancer, Mental disorders and Injuries), which are normally related to excess consumption. The burden of non-communicable diseases is likely to increase

with the changing age-profile of the population of the country—it has been estimated that over the next two decades the population over 60 years in age will double. As a result, it is projected that the share of non-communicable disease in the total disease burden will rise from 33% in 1998 to 57% by 2020. Another factor that contributes significantly to the burden of disease in the country is the persistent high level of malnutrition amongst the general population of the country. NFHS-2 (1998-99) revealed that 37% of the women showed chronic energy deficiency; 42% of the high-income women and 60% of the low-income women suffered from anemia; 47% of the children under age 3 years were underweight, while 18% of the children from the same group were severely underweight. The widely prevailing condition of mal-nutrition, mainly amongst women and children, itself becomes a significant cause of heightened vulnerability to diseases.

Population Stabilisation

A major area of concern in the health sector with wide implications for overall development is the burgeoning population. With a concerted effort towards stabilisation of population growth the average annual exponential growth rate of population has been reduced to 1.93% in the 1991-2001 decade from 2.14% in the 1981-91 decade. The country faces a huge challenge because of the demographic profile of its existing population. The percentage of the population estimated to be in the reproductive age group is in excess of 58%. Even though the Couple Protection Rate has quadrupled between 1971 and 1999, the figure for the latter date is only 44%. Thus, the national programme for population stabilization is still a long way from even a moderate level of achievement. Even when our expectation of a substantial tapering off of the TFR over time is realized, the momentum of the enormous existing population in the reproductive age group will lead to a large increase in the aggregate population over

the next few decades. Only after the reducing trend of TFR impacts on the population over a period of several decades, a reduction can be expected in the annual incremental growth of population, eventually leading to population stabilization by the projected date of 2045 given in the National Population Policy-2000. One key statistic is that 45% of the increase in population is through children with a birth order of three and above. In this backdrop, the effort towards population stabilization will have to rely on bringing about a behavioural change, so that couples are self-motivated to plan for small families.

At this stage it would be appropriate to highlight that there is a wide disparity in the status of population stabilization in different parts of the country. Six states covering 11.4% of the population have already achieved replacement levels of fertility (TFR: 2.1). At the other end of the spectrum, there are eleven states, covering 60% of the population, that still show a TFR of over three. Out of these the five most populous and underdeveloped states – Bihar, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh – will contribute the larger part of the increase in population over the next fifteen years. Looking to the current demographic trend profile, a massive effort would be required to achieve the targets set under the National Population Policy – 2000 i.e. to bring down the total fertility rate to replacement level by year 2010 (2.1) and to achieve a stable population by year 2045.

Structure of the Public Health Organisation

The structure of the public health organisation in the country is pyramidal. Typically, the district-level health organisational structure consists of a general hospital at the district headquarters. At the next lower level, covering a normative population of 1, 00,000, is the Community Health Centre (CHC), which also serves as the first referral level. The responsibilities

of CHCs relate to preventive, promotive and curative services. The services provided are both inpatient and outpatient care. The centres are equipped with some diagnostic infrastructure and also have some clinical specialists attached to them. The tier below the CHC is the Primary Health Centre (PHC) covering a normative population of 30,000. Conceptually, the PHC is the organisational pivot through which integrated preventive, promotive and curative services are delivered in the field to the entire population within the area. The PHCs are structured to provide both outpatient and inpatient services but do not have sophisticated diagnostic equipment or O.T. facilities. Below the PHC in the organization structure is the Sub-Centre (SC), with a normative coverage of a population of 5000. SCs are expected to provide some field services in the domain of community health, as also some outpatient services. As in year 2004 the total number of service centres in the country were: CHCs–3215; PHCs–22974; and SCs–142611. The norms for the different tiers of the public health organisation are quite dated and are very sparing looking at current expectations of quality of service delivery. However, even on these modest norms, the statistics show huge gaps in the availability of service centres—CHC: 68%; PHC: 31%; SC: 29%. Providing additional service centres in the rural areas based on the norms would require an additional capital expenditure of Rs.9700 crores and an additional recurring expenditure of Rs.3500 crores. Furthermore, even out of the service providing centres that exist on the record, many are so degraded as to virtually be unusable. Statistics of availability of medical personnel also show huge normative gaps—Doctors: 39%; ANMs/Midwives: 17%; MPWs: 47%; Pharmacists: 22%; Paramedical Staff: 18%. Though the different tiers of the public health organisation are expected to perform the duties as described above, in reality only the best of them do so; most perform only a fraction of their functions, while many, with a totally degraded infrastructure and poorly motivated and inadequate staff, are

virtually moribund. These factors also greatly limit the contribution of public service centres to the health system.

As mentioned earlier, the aggregate contribution of public health services as a percentage of the total health services provided in the health system, for certain key categories, is inordinately low for a developing country. In the aggregate, the public sector provides 18% of the outpatient care; 44% of the inpatient care; 54% of the institutional deliveries; 60% of the pre-natal care visits; and 90% of the immunization. Out of the aggregate services accessed by below-the-poverty-line (BPL) citizens, the quantum originating from the public health sector is: 93% of immunization; 74% of pre-natal cases; 69 of institutional deliveries; and 60% of inpatient treatment. The statistical exception is the category of outpatient care, where only 31% of BPL citizens utilising such services can access them at public health centres. Looking at access to services across different consumption quintiles, the access to inpatient treatment increases with rising consumption quintiles—the ratio of the highest to the lowest quintile for aggregate inpatient services accessed (both public and private), is 6. The same ratio separately for public and private services is 2 & 11, respectively. Statistics for institutional deliveries show a similar pattern. The ratio of the top quintile to the lowest quintile for the number of institutional deliveries is 3 in public service centres and 20 in private service centres. The significance of the higher share of the public health subsidy to citizens of the highest quintile vis-a-vis the lowest quintile, will be discussed in a subsequent part of this monograph. Finally, looking at the break-up of distribution of health services between the rural and urban areas, the former accesses 68% of the curative care services as against its 75% share of the population. Here again the access is skewed against the rural areas. Another regressive trend is the fact that the public health outlay in respect of communicable diseases

has come down in the period 1988-2001 from 58% to 47%. The reduction of percentage outlay for this portion of the burden of disease, for which the therapeutic drugs are both effective and low cost, is a worrisome trend. Overall, it can be said that the contribution of the public health services appears to be low considering ours is a developing country with a large population of the poor.

Though the general structure of the public health organization is as described above, significant departures have been made from it to meet special contingencies. For the heavy burden diseases (Malaria, TB, Leprosy, Cataract Blindness and HIV/AIDS) and for certain 'broad-span' programmes (Polio Eradication, Family Welfare and Reproductive and Child Health), exclusive vertical field organisational structures have been provided. The characteristics of the diseases covered under vertical field structures includes: heavy disease burden, particularly on the poor; the appropriate strategy involves dissemination of public goods; and the programme is based on effective and inexpensive interventions. This modality has been resorted to in circumstances where it is felt that it would otherwise be impossible to significantly reduce the prevalence level of these heavy burden diseases, or to effectively implement the priority 'broad-span' programmes.

Private Sector Healthcare

To complete the overview of the health services in the country, it would now be appropriate to turn our attention to the quality of the services in the private sector. It is widely documented that untrained personnel provide a large part of the private health services; many practitioners trained in the Ayurveda System are also known to regularly prescribe and use allopathic therapeutic drugs. Studies at scattered locations have shown that a vast number of private service centres lack basic infrastructure and personnel and operate

without any registration/licence. In the absence of any statutory standards for personnel/clinical procedures/institutions, treatment regimens are often unscientific and profit-driven. Quality standards for drugs/vaccines/blood products are statutorily fixed. However, the powers for enforcement rest with the state governments, and for a variety of reasons remain virtually unimplemented.

It has been estimated that the private sector accounts for 58% of the hospitals in the country, 29% of the beds in the hospitals and 81% of the doctors. Several studies have shown that the cost of private health services, both inpatient and outpatient, is substantially more than that of similar public services. Private outpatient services in different studies have been found to be 20-54% higher while inpatient services have been found to be 107-740% higher. In this background, without any risk of exaggeration, it can be generalized that, to a large extent private health services are exploitative. Critics have sometimes called these facilities as belonging to the 'Private Medical Sector' rather than the 'Private Health Sector'.

Of late there has been a sudden proliferation of high-tech, high-cost speciality/super-speciality private hospitals. These cater to the uppermost income decile of the population. Some apprehensions have been expressed that such a trend would trigger off an inflationary spurt in health sector costs. Such institutions, though high visibility ones, are relatively few in number –the speciality/super-speciality tertiary institutions are only 1-2% of the total number of private institutions, while corporate hospitals are less than 1%. Whether such small numbers of five star medical facilities will impact upon the national health sector costs, is a moot point. What is certain is that such facilities can never be expected to contribute significantly to the national goal of universal health coverage.

However, while mentioning the higher costs of health services, there is also some fresh evidence

that primary sector healthcare services are being made available by NGOs at very nominal costs. A desk-study carried out by the present author of the health services provided by five leading NGOs in the country (Voluntary Health Association of India, Karuna Trust/ Vivekananda Foundation, Voluntary Health Services-Madras, SEWA-Rural and Ashish Gram Rachna Trust) has indicated that they have been able to provide quality primary sector healthcare services at stunningly low delivery costs. The cost for the services has been found to range between Rs.21 and Rs. 91 per year at the 2000-01 level of costs. A cautionary caveat needs to be entered here that all these schemes do not provide an identical range of services. However, the range is quite ample in all cases, and compares well with the services offered at a well-functioning state PHC. Also, in all these cases there has been a marked improvement in the basic health indices of the covered population over the life of the project. These NGO initiatives provide a credible pointer that it is possible to organise primary sector healthcare services at affordable costs.

It is sometimes asserted that the utilisation of public health services is low because people prefer the superior private health services. Sometimes this may be true, but certainly not always-quite often the individual would not have the financial resources to obtain the private health services. It is perhaps more likely that, since overall resources in the public health services are so meagre, many in the poorer section cannot access such services, despite their need. An analysis of the data made available from the 52nd Round of the NSSO has revealed that as many as 17% of the people did not seek care when ill, and out of this 47% was for reasons of inadequate access i.e. financial incapacity, distance from service centre, etc.

Availability of Drugs

India has a very active and low-cost pharmaceutical industry. Perhaps, no other country in the developing

world has such a robust drug-manufacturing sector. There are as many as 20,000 manufacturing units, many of them in the small-scale sector. The value of bulk drug/ formulations produced in the country was estimated at Rs. 17000 crores, with the exports notching about Rs. 13000 crores in year 2004-05. Before the introduction of the new Patent law in 2005, the Indian law protected only process patents in the pharmaceutical sector. Indian entrepreneurs in the sector used their ingenuity to devise original manufacturing processes to manufacture molecules that were still within the protected period of product patents. Through this, India's health sector needs were substantially met through very inexpensive indigenous production; imports of pharmaceutical products were limited to a small volume, largely made up of state-of-the-art drugs for some life-threatening non-communicable diseases. Globalisation and

the new provisions under TRIPS have changed the scenario somewhat, and that will be discussed in a later section of the monograph.

Health Sector Manpower/ Infrastructure

In the context of the current status of the public and private health services, as described in the earlier part of the monograph, a certain aggregate quantum of health services are available in the country. It would now appear appropriate to briefly discuss its adequacy looking to the global standards. A statistical comparison of the data relating to manpower, infrastructure and volume of services (both public and private sector) available in India in comparison with that in other countries of the globe, is given in the statement below.

International Comparison of Health Manpower, Hospital Beds and Health Service Utilisation

Area	Physicians per 1000 pop	Nurses per 1000 pop	Midwives per 1000 pop	Hosp. Beds 1000 pop	Inpatient admissions Per Year (%)	Average Length of Inpatient stay (days)	Outpatient visits per capita per year
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
India Public Sector	0.2	N.A.	0.2	0.4	0.7	14	0.7
India Total	1.0	0.9	0.2	0.7	1.7	12	3.9
World	1.5	3.3	0.4	3.3	9	13	6
Low Income Countries	1.0	1.6	0.3	1.5	5	13	3
Middle Income Countries	1.8	1.9	0.6	4.3	10	11	5
High Income Countries	1.8	7.5	0.5	7.4	15	16	8

Sources:

- (i) India Data – Col 2–(CBHI, 1995 & MOHFW, 2000).
 (iii) India Utilization data-(Col. 6, 7 & 8)-52nd Round NSSO (1998).

- (ii) Nurses and Midwife data-(WHO: 1999).
 (iv) All else-World Development Indicators (2000).

From the above it will be observed that, broadly speaking, the availability of medical/paramedical personnel, as also the availability of hospital beds in India, is much lower than the world average, and is often lower than the average of other low-income countries. The service delivery centres are also known to be handicapped on account of the paucity of medical consumables, basic infrastructure and financial resources.

In the medical sector the country has 229 medical colleges producing 25,600 graduates and about 10,000 post-graduates every year. Out of these medical colleges, 125 are in the public sector. The scope for post-graduate specialisation is very large – the number of post-graduate seats available in a year is 39% of the total number of graduate level seats in medical colleges. Despite this, large unmet technical manpower requirements persist in many parts of the country. There is a particularly acute shortage of specialists in certain key clinical disciplines – surgeons, pediatricians, gynecologists and anesthetists – resulting in major bottlenecks in the functioning of public service centres.

Health Security

Compounding the above-described situation is the fact that only a very small portion of the population is protected by a health security scheme. The most optimistic estimate of the population covered by any type of health security scheme is 11% (CGHS: 4.4 million; ESIS: 35.3 million; Community-based insurance schemes: 30 million; Employer-based insurance: 30 million; Private health insurance: 7.6 million). As has been highlighted earlier, an inordinately large component of the health services in the country are provided by the private sector. A common complaint is that the quality of services at public service centres is poor and for that reason people prefer to go to private service centres. The inadequate facilities in the public services and the indifferent attitude of the service providers, is well known. The shifting of service seekers to private

service providers may be true to some extent, but in a large number of cases inadequate financial resources would preclude any such option. Private funding of health services is largely out-of-pocket expenditure – provision of free services by NGOs and faith-based organizations being miniscule. The transactional process for individuals trying to obtain private health services does not ensure cost-effective purchase, nor is the package of treatment effectively linked to essential medical needs. Moreover, the out-of-pocket expenditure can be incurred only when the individual has financial liquidity. There may be many episodes of illness when the individual is without financial resources and has to rely on unsecured loans in the informal credit market. This creates a serious threat to the health and financial security of large numbers of people. As a result, emergent medical requirements often become catastrophic financial contingencies for poor families. To depict this weakness in more graphic terms: an Indian who is hospitalized spends more than 50% of his annual income on health; 24% of those hospitalised fall below the poverty line; and these out-of-pocket expenses can push as much as 2.2% of the population below the poverty line in a year.

Summation

In summation, the Indian health scenario is one of glaring shortcomings. Public health services are meagre in scale and sub-standard in quality, and private health services are high cost and inadequately spread over the country. Inadequate public resources are being allocated to public health services. Even a modicum of health security is not available to the larger part of the population of the country. The policy-makers in the country, no doubt, are aware of the acute shortcomings in this sector and are trying to put together a sustainable plan for ensuring a minimal standard of good health amongst the general population. The experience of Indonesia and Thailand in attempting to develop their national health systems will be used in a subsequent part of this monograph to prescribe a possible structure for a future health system in India.

III. INDONESIA

Indonesia is a country with the fourth largest population in the world—207 million (WHO: 2000). Geographically it consists of over 17,500 islands, most of which are very small; over 6,000 of these are populated. Indonesia's health system underwent substantial expansion and improvement in the two decades after establishment of the 'New Order' Government in 1965. This coincided with a period of remarkable growth of the economy—the per capita income rose from US\$ 50 in 1968 to US\$ 1124 in 1996. However, after the Southeast Asian financial crisis the per capita GDP slumped to US\$ 600 in 1998. The 'New Order' government implemented a very effective development strategy through the four Five Year Plans (*Pelita*) stretching from 1968 to 1987. With the massive expansion of the public health services in the 1970s and 1980s, there was a significant improvement in the health status of the community. It is noteworthy that Polio is now close to elimination. Also, significantly, routine immunization is steadily maintained at a level above 80%. The basic health indices—IMR, LE and CDR—have shown an impressive improvement over the last three decades. IMR has declined from 142 to 41 in the period 1971-98; LE has improved from 46 to 68 over the same period; and CDR has dropped from 18.7 to 7.5 over the period. Today the high prevalence diseases in the country are TB, Malaria and Dengue Fever. Indonesia is currently witnessing a classic phase of 'epidemiological transition'—it suffers a double burden of disease. The incidence of non-communicable diseases is showing a rising trend, while the trend for communicable diseases is relatively muted. Health services for mothers and children are known to be inadequate—about 50% of women give birth without being assisted by skilled attendants. During the last decade the population growth in the country has averaged 1.5% annually.

While the 1970s and 1980s was a period of immense

achievements in the health sector, the 1990s saw a total reversal of that trend. On account of financial stringency, since 1993 Indonesia has adopted a 'zero growth' policy for the health sector. The adverse impact of that was further exacerbated by the onset of the East-Asian financial crisis in 1997. As a consequence, the general health scenario in the country today is bleak with inadequate allocation of resources and meagre coverage of services.

Public Health Organisational Structure

The existing organizational structure of the public health system of Indonesia, sequentially from apex to base, consists of five levels: Central; Provincial (Regional Health Office); *Kabupaten* (District Health Office); *Kecamatan* (Sub-District level); and sub-health centres. Normative health service facilities are provided at each tier of the public health system. A medium-sized hospital is the normative first referral facility for each district. The tier located at the sub-district level, is the community health centre (CHC), locally known as '*Puskesmas*'. The role of the CHC is to provide comprehensive outpatient services, along with other public health goods in the state sector, within a sub-district of 30,000 population. CHCs are provided with a normative strength of doctors, nurses, vaccinators, midwife and administrative assistant. The health service centre below the CHC is the sub-health centre covering a population of 10,000. Such sub-centres are minimally staffed with one nurse/midwife and one auxiliary nurse. Technical guidance, referral services and material assistance is provided to self-reliant community activities in the health sector, by the lowest level—i.e. the sub-centre. In statistical terms, the aggregate infrastructure in the national health system in 1999 was: hospitals (including private sector)—1090; CHCs—15 768; sub-

health centres- 27,600. Public hospitals constitute 55% of the total number of hospitals in the country, providing 35% of the beds in the health system. Out of the government hospitals, 75% of the hospitals and 90% of the hospital beds are located in urban areas – this is a surprising statistic clearly showing a rural-urban inequity even in the matter of location of public health service centres. The estimated total number of available beds in the country was 1, 20,000.

Historically, Indonesia has had an extremely centralised scheme of administrative powers for its public health system. This was particularly unsuitable for a developing country consisting of several thousands of island entities. To remedy this, in the year 2001 a major exercise of decentralisation of powers was initiated. Under this exercise, funds were transferred to local self-government institutions at the decentralised level and related administrative powers were also delegated to lower formations. Additionally, fiscal powers were transferred to the local-self-government institutions so as to enable them to raise their own resources. The benefits of the decentralisation exercise can only be assessed after some time when the new scheme of delegation of administrative power has stabilised. In the context of the decentralisation process, the position of the provincial government has become somewhat anomalous. Under the scheme of decentralization the development funds are channelised directly to the district level, bypassing the provincial government. Overall control is also exercised by the central government over the district level programmes. This procedure for routing the funds would certainly save time which otherwise would be taken up at the provincial level. However, the technical supervision and administrative oversight cannot entirely be centralised in the federal government. In a large country consisting of scattered islands it is unrealistic to expect effective supervision at the distant federal level. The managerial problems faced in such radical decentralisation have been faced in India when central government funds were directly allotted to the

districts bypassing the state governments. The state governments tended to totally disown the projects and did not consider it a part of their functions to exercise any sort of technical supervision over the activities. The efforts of the central government to exercise the supervisory functions at its level were totally ineffective, and as a result most of the schemes where such drastic decentralisation was resorted to, ended up in near anarchy. Looking to the distance between the federal government and the district administrations it would appear appropriate if the responsibility of first-level technical supervision was explicitly placed on the provincial government. The provincial government could ensure that the technical guidelines are implemented, and in rare cases where there is persistent violation, it could even advise the federal government to discontinue funding. However, the funding procedure could continue to directly link the district administration to the federal government, so that there is no possibility of capricious use of provincial level discretion in the matter of release of funds, and also no time is lost in the processing of distribution of funds at the provincial level.

Expenditure in Health Sector

The total health expenditure for the country as a percentage of GDP is 2.7% (1999-2000); out of this the public health expenditure is 0.7% i.e. 26% of the expenditure is public spending. Conventionally, a health sector expenditure target of 5% of GDP is considered appropriate for a developing country. The public spending is tax-based revenue, supplemented with international funding. Private health sector expenditure at 74% is inordinately high for a developing country. Out of private expenditure, 96% is out-of-pocket expenditure. In monetary terms, the public health expenditure is US\$ 4.74 per capita per year out of a total health expenditure of US\$ 20.01. Public health expenditure is almost entirely (90%) funded by the central government. Per capita public outlays in the health sector showed a significant

increase in the late 1980s; total public health spending nearly quadrupled between 1987-88 and 1992-93. This was the period of economic boom. The outlays have steeply slumped as a result of the subsequent Southeast Asian financial crisis.

Impact of Southeast Asian Financial Crisis

The Indonesian economy, and the national health sector as a part of it, suffered a traumatic shock in the wake of the Southeast Asian financial crisis. In 1997-98 and 1998-99 the sectoral health budget did not reflect the usual incremental resources given year-on-year to the health sector. This combined with the steep devaluation of the local currency, reduced the health sector outlay in dollar terms and resulted in a sharp contraction of the purchasing power. In statistical terms, the per capita public health expenditure at constant prices (Base year: 1984-85) fell by 2.9% and 6.6% in 1997-98 and 1998-99 respectively. It was only by 1999-2000 that the public health spending revived to the level of the average achieved in the period from 1992-93 to 1995-96. In the crisis period the public health system could only be sustained, although only to some extent, through a massive increase in foreign funding. The foreign component of public health spending, which averaged 10% in the earlier years, rose to 25% in the period from 1997-98 to 1999-2000. In the post-crisis period, health service costs rose sharply, with a consequential decline in the utilisation of services. What was even more alarming was that the decline in the utilisation of services was the steepest in outpatient and primary sector services; while the decline in hospital services was only marginal. In statistical terms, during the period of financial crisis (1997-98 to 1999-2000), while government

hospital expenditure in nominal terms rose by 22%, that for primary sector services fell by 10%. The period showed a decrease of 17% in overall contact frequency—a 26% fall in the public sector and a 9% fall in the private sector. The curtailed availability of health services in the period of crisis consequently resulted in higher levels of morbidity. The National Socio-economic Surveys (*Susenas*) conducted in 1998 and 1999 showed sizable increase in morbidity compared to the pre-crisis period, particularly in the far-removed provinces. The National Socio-economic Survey (1998) recorded a morbidity level 16.5% higher than in the previous year. Thus, though the health sector was under severe strain in the period after the financial crisis, a catastrophic national health setback was barely averted through increased recourse to foreign funding.

Equity of Access to Healthcare Services

The national health scene was also characterized by marked inequity in access to healthcare between different strata of society. The poverty level in the country was high - it was estimated that in 1998, 24.2% of the population was living in poverty, and as much as 58% of the population lived on less than US\$ 2 per day. *Susenas*, 1999, gives the reported illness and service utilisation rates for different consumption expenditure quintile as per the statement below.

Reported Illness/Service Utilisation Rates by Expenditure

Category	Consumption Expenditure Quintiles*					Ave.
	1	2	3	4	5	
Outpatient	189	193	191	187	168	185
Hospital	1.8	2.0	2.1	2.3	2.4	2.1
Specialist	11.9	14.2	16.0	17.7	24.1	16.8
Cases of Sickness	265	251	242	226	198	236

* Per 100 population

From the above it will be observed that, except in the category of outpatient services, lower consumption quintiles have markedly less access to health services than higher consumption expenditure quintiles. The skewed access to services is most noticeable in respect of the high cost services— Specialist and Hospital Services. The inequity in access to health services available is borne out by the statistics of untreated cases in different consumption quintiles—the ratio between the lowest and the highest quintile is as high as 5.8. In the context of the above observation it would be useful to also review the pattern of utilisation of different categories of public and private service centres. The relevant statistics are reproduced below.

Percentage Utilization of Different Categories of Health Services

Category of Service	Consumption Expenditure Quintiles				
	1	2	3	4	5
Private Sector					
Specialist	10	14	17	21	39
Hospital	3	8	17	19	52
Public Sector					
Specialist	17	19	20	21	22
Hospital	25	25	22	23	5

It will be observed from the above that the utilisation of private specialist services and private hospital services is much greater for the highest consumption quintile compared to the lowest consumption quintile - four times in the case of specialist services and seventeen times in the case of hospital services. The specialist/hospital services in the public sector are distributed more evenly between different consumption quintiles. It has been estimated in a World Bank study that the highest consumption

quintile captures 29% of the public healthcare subsidies, while the poorest quintile accesses 12% of the subsidies. The statistics of those in different expenditure quintiles, who receive no care, are also very skewed - while 8% of the highest quintile went untreated the same statistic for the lowest quintile was 46%. The above details clearly reveal that the skewed access to health services, both in public and private sector, must be attributed to existing financial barriers, whether by way of private sector service fees or public sector user charges. Though a large number of schemes and modalities of service delivery have been tried out over the history of the country, health security is still only available to a very small fraction of the population. The people

who get free outpatient/inpatient services either through Medicaid or otherwise, are only 6.2% and 5.4% respectively of the total population. These figures are required to be seen against the fact that 24% of the population lives below the poverty line. The larger part of the population, therefore, has to chance its luck in the limited public health sector or in the more expensive private health sector.

As has been mentioned earlier, 76% of the total health expenditure is privately funded, and out of that 96% is 'out-of-pocket' expenditure. The high 'out-of-pocket' expenditure itself exacerbates the inequity in distribution of health services between different economic sections. It has been estimated for 1997 that out of the 'out-of-pocket' expenditure incurred for various healthcare services/products, the top 20% of the population utilised 54% of the services, while the bottom 20% utilised only 5% of the services. In totality, in spite of all attempts to maintain public health outlays, public health spending was not fully protected in the post-crisis period. Overall, the condition of the health system in the post-crisis period can only be described as precarious.

Rural-Urban Skew in Access to Health Services

Another negative feature of the health system is the skewed distribution of health services between the rural and urban areas. For 1997, a survey found that the rural-urban ratio of utilisation of different private health services ranged between 0.28 and 0.74; the ratio of utilization of different tiers of public health services (except inpatient services) ranged from 3.13 to 4.66; and the ratio of use of untrained practitioner/ traditional healer ranged from 2.54 to 2.56. The disaggregated statistics clearly indicate that vis-à-vis the urban population the rural population is handicapped in obtaining primary healthcare from a private doctor and secondary healthcare from a public or private service centre. It is also observed that the rural population has to depend more on the public health system than the urban population, and, failing that, also depend more on untrained/ traditional healers. In short, the rural population has less access than the urban population to the more preferred sources of health service delivery. The geography of the country in the form of scattered islands also results in uneven distribution of healthcare services. Despite the enormous expansion of span of services in the 1980s and 1990s, at the end of the period less than 25% of the population lived within a five-kilometre radius of a health service centre.

Indonesia presents a curious paradox. While the average access to health services is low, capacity of service centres, particularly in the private sector, is substantially underutilized. The average per capita private expenditure is very low, and there is a wide difference between the expenditure made at the highest and lowest consumption cohorts. The distribution of the health care expenditure is such that the expenditure of the top 1% is 19 times that of the average.

Health Sector Manpower

Indonesia's capacity in health education is adequate. It has 33 schools of medicine out of which 16 are in the public domain with an annual enrolment capacity of 3500. At the post-graduate level, there are ten public medical schools turning out between 350 & 600 specialists per year. The number of general practitioners is small compared to international norms. Post-1990 all graduating doctors are required under statute to serve the government for two years before becoming eligible for post-graduate specialisation. Since 1993 government recruitment has completely stopped. There is, therefore a surfeit of young doctors in private practice in certain areas of the country. The normal observation is that in times of economic boom doctors leave government employment and enter private practice; and in times of recession private practice offers poor prospects and so young doctors clamour for government jobs. The total strength of doctors (private and public) has been estimated to be 32,000, with 13,600 in the state sector. Taking the country as a whole, there is a shortage of doctors, and considering the spatial maldistribution large areas of the country are underserved. It was estimated that in 1997 there were 1,50,000 nurses in the country out of which 80 000 were in public hospitals; it is estimated that 40,000 of the nurses are unemployed. The estimated numbers of pharmacists and midwives in the country in 1997 were 7646 and 6,12,003 respectively.

User Charges

Right from the time of the first financial crisis faced by Indonesia in 1985 in the aftermath of the oil crisis, the government has been trying to lighten the financial load of the health sector on the budget, by experimenting with alternative health financing schemes. As a part of this exercise, user charges came to be introduced in public sector services. The normal incidence of user charges is 20-30% of the

cost of the service for which it has been introduced. However, even after that 80% of the cost of providing the integrated public health services is funded from the budget. The public hospitals are increasingly being given operational autonomy under the local expression *Swadana*; many of these have been converted into public sector corporations. In many cases of autonomous or corporatised hospitals it has been found that they swing to the other extreme by raising user charges inordinately, in some cases even higher than private sector charges. As a result many citizens were screened out from access to the services because of financial incapacity, while some switched over to the cheaper private service centres.

Availability of Drugs

Domestic manufacture of pharmaceutical drugs is very limited. In the year 2000 there were 203 manufacturers in the country, out of which 169 were local entrepreneurs. However utilisation of the local capacity is as low as 40-50%. Over 90% of the drugs consumed in the country are imported. As a result of the financial crisis of 1997, the domestic price of drugs rose several-fold. To meet the situation, government introduced a price control mechanism. However, many of the manufactures responded to this by shutting down production. The crisis had a significant impact on the composition of the basket of drugs used in the country. The usage shifted from branded-generics / patented drugs to ordinary generics. A deleterious tendency noticed in the period was the consolidation of production capacity with the MNCs even for drugs outside the patent domain. The category-wise break-up of the drugs consumed in the country is: Patented-10%; Generic Branded-70%; and Generic-20%. In the year 2000 government use of pharmaceutical products as a percentage of total use of these products, was 10.3%. This figure indicates that in the public sector the ratio of expenditure on pharmaceutical products vis-à-vis

the expenditure on manpower, is too small to make for an optimally efficient health system. The per capita drug expenditure which was US\$ 5.16 in 1997, dropped steeply to US\$ 2.27 in 1998 in the post-crisis period, a marked contraction of purchasing power i.e. volume of drugs consumed. In the subsequent years it has gradually improved, but even in the year 2000 it was below what it was in the pre-crisis years. The per capita expenditure on drugs dropped by 0.8% between years 1991 and 2000.

Community-Based Schemes

While considerable progress was made in the 1970s and 1980s, the health services in the country still remained grossly deficient. Being a country of islands the health system faced unique logistical problems. Even by the end of the 1980s decade, less than 25% of the population resided within five kilometers distance from the nearest health service centre. In this situation of inadequate access to health services the government tried out a large number of conceptually varied schemes in order to discover a more cost-effective system than that provided by the conventional public health administration. The features of some of the more significant experiments are summarised hereafter.

- (a) A large-scale network of integrated service posts – *Posyandus* – was established. These were community service centres that supplemented the State service centres. This scheme had a mixed financing pattern, with a significant non-state component. Trained community health volunteers ran these service posts, with supplementary technical support from the government functionaries at the public service centres. The services offered under the scheme were what can be called basic family health services covering: MCH, family planning, nutrition, immunization and treatment of water borne diseases. It has been reported

that by 1998 the network included 243 783 *Posyandus* covering 66 000 villages, supported by 10.78 million active volunteers. While one may not be very sure about the large numbers mentioned in official statistics, it can be assessed that overall the scheme served a useful purpose of supplementing health services through community participation.

- (b) From 1980 onwards, under a concept known as *Dana Sehat*, small community-based, voluntary social insurance schemes were encouraged. The scheme, while attractive *ex-facie*, turned out to be impractical. Contributions found affordable by the participants were too small to offer a worthwhile package of health cover. Also, the membership of each scheme was often so small that it offered no element of risk pooling, which is an essential component of any social insurance scheme. As a result of these limitations, the scheme, for the greater part, remained only a statement of good intentions.

Resource Needs

With the increase in life expectancy and the changing epidemiological profile, the quantum and composition of medical services required in the country is also changing. The country is at an advanced stage of planning for the introduction of an Integrated Social Security Scheme, with a Social Health Insurance Scheme as a key component. To establish the service delivery modules for implementing future plans, as projected for the year 2015, on a normative basis the requirement of additional services of different categories would be - primary care: 77%; specialist care: 168%; and hospital care: 139%. The number of hospitalization cases is projected to rise from 5.9 million in year 2000 to 14 million in the year 2015. Corresponding to that, the requirement of hospital beds is estimated to rise by 96%. It is estimated that

cost of setting up additional facilities for meeting normative health service standards would be: US\$ 11.6 billion, with the following break-up:

Restoration of public health system-US\$ 3.0 billion.

New hospitals-US\$ 3.4 billion.

New clinics-US\$ 2.7 billion.
(general practitioners and specialists)

Establishment of private insurance programmes-US\$ 2.5 billion.

Health Security Schemes

As has been mentioned earlier, the public health outlay in the country is inadequate. The private health expenditure is sporadic and generally does not come within the ambit of any health security scheme. Risks on account of episodes of catastrophic illness, and consequential financial distress, are high. Putting aside for the time being the issue of paucity of financial outlays, it is noteworthy that the country has been experimenting with a variety of financing mechanisms in an attempt to improve the health security of the citizenry. The key features of the more significant experiments are summarized hereafter.

- A health security scheme mainly for government functionaries and their families identified under the acronym ASKES. This is funded by contributions by the enrollee and the government. The outpatient health services are provided by public health service centres, while the inpatient services are provided by both public and private health service centres. Outpatient services are compensated for through capitation fees, while inpatient services are compensated through a 'fee-for-service' mechanism. Administrative costs are low at 5%. The scheme has not proved to be

very popular because of the sub-standard quality of services and high co-payment charges. About 14.5 million individuals are covered under the scheme.

- An independent security scheme under the name of *Jamsostek* is operated for the formal sector covering private sector employees. However, the scheme permits establishments to opt out if they have an alternative health security scheme. As a result, the membership under *Jamstotek* is limited to 1.3 million enrollees and 2.9 million beneficiaries, which is only 5% of the eligible group. This scheme does not cover retirees. Overall, the scheme has not proved to be a success. The pool of people covered by the insurance is not large enough to enable pooling of risk and consequential operational efficiencies.
- In 1992 government introduced a statute to regulate the operations of Health Management Organisations. The schemes came under the acronym *JPKM*, and were in the nature of pre-paid health insurance schemes operated through insurance agencies known as *Bapel*. *Bapels* are 'for-profit' enterprises. Compensation for the services was on the basis of capitation. Beneficiary perception was that the scheme offers better services than state health insurance schemes. So far 24 *Bapels* have registered and started operating in the country. However the experiment has also not proved very successful—the total coverage is limited to 1.2 million individuals, with most schemes having a membership of less than 10,000. The premium under the scheme is based on individual risk assessment, and this precludes the possibility of large composite pools having a broad and representative composition of risk. The scheme requires a large contribution on the part of the enrollees, thus making it unattractive.

- During the period of financial crisis an experiment was tried out under the Social Security Network, by providing health services through *pre-Bapel* type mini-health insurance agencies. These entities were state-funded and the scheme managers were entitled to 8% management fees. The *mini-Bapels* constituted small pools of individuals where experience could be gained in the operating of a health management organization. It was planned that in due course of time, with the gaining of experience, *pre-Bapel* entities could be merged into the regular *Bapel* format. The experiment failed as the pool of beneficiaries under each *pre-Bapel* was too small and the management personnel did not have requisite skills.
- There are 64 private companies operating conventional private health insurance schemes. These private initiatives have not met with much success—the overall coverage is only 4 million and that too only from the higher economic strata. Administrative costs are also unacceptably high. This does not provide for pooling of risk and is more in the nature of a savings scheme dedicated to use of funds for medical treatment during episodes of ill health.

The expectation - that various types of insurance packages could be offered by private entities operating in a free market at affordable premia rates—was belied. It became increasingly clear that any broadly spread social health insurance scheme would have to rely on state funding to a considerable extent.

The total population covered by any type of health security scheme is limited to 29.4 million (13.8% of the population): *JPKM(HMO)*—1.2 million; *JPKMASKE*—13.8 million; *JPKM Jamsostek*—2.9 million; private health insurance—4 million; military personnel—2.5 million; health services provided by employers—5.0 million.

Summation

In summation, the current Indonesian health scenario is a fairly depressing one. Overall health expenditure is low, and within that public health expenditure is unconscionably low. The organisational structure needs to be decentralised while at the same time ensuring that the necessary technical supervision is exercised at the intermediate provincial level. Access to health services is highly uneven across economic strata and between rural and urban areas. A variety of community-based schemes, including social health insurance schemes, have been tried out; important operational lessons have been learnt from these experiments, even though as practical schemes they have failed. The decentralization of

fiscal powers is not likely to yield huge resources to the decentralized entities in the immediate future; hence the central government would be required to contribute an increasing amount to the public health kitty in the foreseeable future. The logistical problems faced by a country consisting of a myriad island entity, are enormous, and would result in higher unit costs for health services. In this situation, private health services are less likely to meet the needs of such areas. In the transition period during the introduction of the social health insurance scheme, public health services would have to be sustained, indeed strengthened, in order to meet the health needs of the section of society that is currently denied health services in both public and private sectors.

IV. THAILAND

Thailand is a country with a population of 61.4 million (2000). It is a developing country in the low range of the middle-income category. Its per capita GDP was US\$ 2060 in the year 2002. The country's population grew at the rate of 0.93% per year in the period 1995-2000, and the population profile is a rapidly aging one. The life expectancy was 69.9 years for males and 74.9 years for females. The elderly population (over 60 years) was 8.6% in year 2000. In the last three decades there has been a marked drop in the IMR (2001:21.5) and MMR (2001:12.9). However the rural-urban variation is very wide – MMR in the rural area is 1.85 times that in the urban area. The health scenario is undergoing an epidemiological transition—the communicable diseases, particularly the vaccine preventable and peri-natal diseases, have shown a marked decline (Measles, Tetanus, Diphtheria, Pertussis, Polio, Leprosy and Malaria); while the non-communicable diseases (CVD, Diabetes and Cancer) have shown an upsurge. This change of trend has also generated a need for change in the parameters of the service module for delivering health services. The number of deliveries attended by trained personnel was 94.5% in 1999. Though the operation of the health system has resulted in a morbidity profile akin to that of a developed country, there are still wide inequities between income quintiles as well as a wide differential across the rural-urban divide.

State of the Economy

The Thai economy has made notable progress in the last four decades. Over that period the per capita income, which was at the level of Sub-Saharan countries, has risen some fifty times in nominal terms. By the nineties, Thailand had substantially become an industrial economy. The economic strategy adopted was one of export-led growth—by 1999 the share of exports had risen to the level of 53% of the GDP.

The national economy grew at the average rate of 7.8% over the last three decades—the break-up of the period covering the last decade and a half was: 10.7% in the period 1987-90 and an average of 8.3% in the period 1991-96; thereafter, in 1997 the country's economy suffered a severe setback, recording growth rates of -0.4% and -9.4% in 1997 and 1998 respectively. The country staged a partial recovery recording a growth rate of 3.5% and 4.5% for 1998 and 1999 respectively. The percentage population below the poverty line dropped from 36% in 1988 to 11% in 1996. During the financial crisis the currency was devalued by close to 50%. In real terms the current per capita GDP is close to the level in 1994. The contracted purchasing power of the citizens in the post-crisis period led to increased reliance on public health services. It was observed that the number of people using public health services in 1997 and 1998 rose by 11.4% and 9.9% for inpatient care respectively, and by 31.1% and 8.8% respectively for outpatient care. While mentioning the negative fall-out of the financial crisis, for completeness it would be necessary to mention one other facet. It has been the observation of many social commentators that the crisis had the effect of inducing communities to increasingly draw upon collective resources to assist those in need in emergent contingencies. It was with the assistance of such reserves of social resilience that Thailand was able to tide over the financial crisis.

Though the country enjoyed buoyant growth till the onset of the financial crisis, the benefits were unequally distributed between different sections of the people. The poorest quintile spent 4.2% of their income on health while the richest quintile spent 1.2% - a 3.4 fold difference between different sections of society. In 1962 the lowest quintile received 7.9% of the national income, while the richest quintile received 49.8%. This deteriorated over time such that in 1998 the lowest quintile received 4.8% while

the richest quintile took away 53.9% of the national income. Thus, while there had been an overall improvement in health standards, significant disparity still persisted between the different sections.

Health Sector Expenditure

The total health expenditure in the country is significantly high even in comparison to developed countries. In year 2000 the total health expenditure was 6.1% of GDP i.e. US\$ 120. The public health budget as a percentage of total national budget was as high as 13.3% in year 2000. Public expenditure is mostly funded through tax revenues (year 2000: 92%). The aggregate per capita health expenditure showed an average growth rate of 8.2% as against an average GDP growth rate of 5.8% in the period 1980-2000. The break-up of total health expenditure was: Public-33%; Private-67%. Out of the private expenditure, 85% is out-of-pocket expenditure. The break-up of the public health expenditure between different inputs was: salaries/wages-47%; operating expenses-44%; and capital expenditure-9%. The statistics indicate that the government gives considerable priority to the public health sector in its scheme of governance. The break-up of the public health expenditure between different categories of initiatives is: curative care-55%; health promotion-19%; and disease prevention-12%. This break-up reveals that the approach is excessively bio-medical and therefore, sub-optimal. It is a widely accepted axiom in the field of public health that preventive and promotive initiatives are much more cost effective than curative ones, and therefore it is rational to invest in preventive and promotive initiatives to the maximum extent required under an optimal public health mix.

Structure of the Health System

The administrative structure of the country, proceeding from the hub to the periphery, consists of 76 Provinces, 876 Districts, 1129 Municipalities,

and 6745 *Tambon Administrative Organisations*. In the Thai healthcare system, the public sector is the main service provider with the private sector and 'private-not-for-profit sector' also actively contributing. Traditionally, the Thai people have relied upon local wisdom and practices for health promotion and curative care; this age-old social tradition was usefully harnessed in meeting essential needs in the period of financial crisis in the late 1990s. However, in the recent past there is a noticeable trend of increasing preference for the modern system of medicare both in the public and private sectors - the use of self-care methods, largely based on traditional practices, has dropped from 57% in 1970 to 18% in 1996.

Distribution of Medical Services

The Health and Family Welfare Survey (1999) has revealed that people living in urban areas use more of private services than public services (38% private facilities; 28% public facilities); while in the rural areas the public facilities are the mainstay (20% private facilities; 55% public facilities). The spatial spread of the health service centres in the country is given in the statement below.

In the early eighties (1982-86), the government adopted a policy of increased focus on rural areas in the matter of expansion and development of health services. This approach led to a very marked increase in the budgetary outlays for rural health services. As a result, decentralised access to health services came to be greatly improved, particularly at the district and sub-district levels.

It needs to be mentioned that there is a large overcapacity of private hospital beds. An assessment carried out by the Bureau of Health Policy and Planning for the period 1995-99 indicated that the bed occupancy for 'for-profit' private hospitals was only 40%, as against the of 83% for public hospitals.

Distribution of Healthcare Infrastructure

	Bangkok	Provinces	Districts	Tambons	Villages	Total
Medical Schools	5	4	-	-	-	9
Specialized Hospitals	19	41	-	-	-	60
Regional Hospitals	-	25	-	-	-	25
General Hospitals (Total)	146	386	-	-	-	532
(a) Public	29	67	-	-	-	96
(b) Private	117	319	-	-	-	436
Community Hospitals	2	-	720	-	-	722
Health Centres	143	-	214	9738	-	10095
Private Clinics	3081	11322	-	-	-	14403
Community PHC Centres	-	-	-	-	72192	72192

Sources: (i) Bureau of Health Policy and Planning, MOPH.
(ii) Rural Health Division, MOPH.
(iii) Rural Health Division, MOPH.
(iv) Medical Registration Division, MOPH.
(v) Office of Primary Healthcare, MOPH.
(vi) Food and Drug Administration, MOPH.
(vii) Department of Health, Bangkok Metropolitan Administration (BMA).
(viii) Department of Local Administration, Ministry of Labour.

Conceptually, a proper referral discipline in the health system requires that in the first instance primary care be availed of at the level of the health centre - as the first-line of service; and the services of the secondary and tertiary level should be available on the referral of the primary service centre. This route is often short-circuited in the

belief that the services in the secondary and tertiary levels are superior. Statistics indicate that, even though OPD visits to decentralized public health centres increased from 29.4% of aggregate OPD visits in 1977 to 46.1% in 1998, the number of patients availing of primary care at secondary and tertiary institutions persisted at an undesirably high level of over 50%.

Inpatient Service Infrastructure

The aggregate availability of facilities in 1997 consisted of 1301 hospitals and 1,32,395 beds, out of which 943 hospitals and 1,02,460 beds were in the public sector. Thus the availability of inpatient facilities for 1000 population (2.2) was higher than the average in middle-income countries, though lower than the world average. The proportion of private beds increased from 7% in 1973 to 23% in 1999. But, despite this, the share of public facilities in this category continues to be markedly large.

Health Sector Manpower

A manpower survey carried out in year 2000 revealed that the country had 18,025 medical doctors, 4,141 dentists, 6,384 pharmacists, 70,978 professional nurses and 31,231 rural health workers. The aggregate availability of doctors is very low

– the index of physicians per 1000 population was 0.3, as against an average of 1.8 for middle-income countries.

Health Sector Training

Most of the training institutions for health manpower in the country are in the public sector- out of the 11 medical schools, 10 are in the public sector; out of 62 nursing colleges, 58 are in the public sector; out of 11 pharmacy faculties, 9 are in the public sector; and, the 6 dentistry faculties are all in the public sector. The cost of education of medical personnel is almost entirely borne by the state (90%). More than 90% of the human resources in the country are

produced from public sector institutions. Investment in health research is relatively low, though it has been boosted substantially in percentage terms in the recent past – it rose from 0.2% of the public health budget in the period 1992-96 to 0.52% in 1999.

Distribution of Health Manpower/ Infrastructure

The health manpower scenario and infrastructure availability is marked by spatial mal-distribution and skewed availability—about 50% is clustered around Bangkok. The availability figures are given in the table on the next page.

**Distribution of Health Resources (Resource: Population Ratio)
By Region, 1999.**

Type of Resources	Bangkok	Central	North	South	North-East	Nationwide
Beds	1:199	1:376	1:478	1:509	1:780	1:455
Health Centres	1:39 346	1:3 660	1:4 047	1:4 090	1:5 038	1:4 304
Doctors	1:760	1:3 653	1:4869	1:4 888	1:8 116	1:3 395
Dentists	1:2 991	1:17 494	1:27 225	1:25 663	1:38 487	1: 15 295
Pharmacists	1:2 132	1:11 458	1:16 610	1:13 382	1:25 954	1:10 158
Nurses (all Categories)	1:252	1:558	1:676	1:605	1:1 064	1:619
Health Centre	-	1:1 055	1:1 293	1:1 205	1:1 691	1:1 342
Pharmacies	1:2 039	1:9 311	1:19 062	1:16 721	1:39 704	1:10 315

Sources: (1) Report on Health Resources Survey, Bureau of Health Policy and Plan, MoPH.
(2) Food and Drug Administration, MoPH.
(3) Rural Health Division, MoPH.

It is observed that the problem of spatial mal-distribution was exacerbated in periods of economic boom (1989-97) and was partially ameliorated in spells of economic recession (1980-88 and post-1997). This is indeed a strange phenomenon - an inverse linkage between individual prosperity for a favoured section and poor availability of public health services for the general public. Since 1970 a problem has been faced in the public sector on account of large-scale migration of trained man-power to developed countries to avail of the more attractive financial prospects there. To secure the availability of trained doctors for the public health system the government imposed a statutory duty of three-year's public service for the fresh medical graduates.

Health Security Schemes

Over the years Thailand had come to introduce several health security schemes with different features – Civil Services Medical Benefit Scheme, Social Security Scheme, Voluntary Health Card Scheme, Voluntary Private Health Insurance and Workmen's Compensation Fund. The broad features of the schemes are summarised hereafter.

- **Medical Welfare Scheme**—This scheme was designed to provide health services to the poor. The income cut-off for eligibility is 2000 baht per month per individual and 2800 baht per month per family. Identification of eligible beneficiaries was entrusted to community leaders. Surveys have shown that as much as 89% of the targeted poor were able to register under the scheme and avail of the services. The scheme provided for both inpatient and outpatient services, and funding was provided on a global basis to the service providers. The per capita expenditure figure under this scheme for year 1999 was 363 baht, though with wide variations between different regions. The aggregate coverage under the scheme

was 40.8% Of the population i.e. 25.1 million 1 million.

- **Civil Servant Medical Benefit Scheme**—This scheme is for government servants, pensioners and their dependants and is a very generous one. It provides for comprehensive outpatient and inpatient services, including surgical services. Both outpatient and inpatient services are generally provided through public service centres. Purchase of services was through the 'fee-for-service' mechanism. This scheme proved to be a very expensive one. Because of their clout the beneficiaries availed of unnecessary procedures and needlessly prolonged inpatient stays. The cost of the services rose at the rate of about 14% per year in the period 1988-97- it nearly doubled in the period 1992-97. The per capita expenditure under the scheme for the year 1999 was 2106 baht, making this expenditure by far the highest under any health security scheme. Coverage is about 12% of the population i.e. 7.4 million.
- **Social Security Scheme (SSS)**—This is a compulsory social security scheme for the formal sector private employees. Services were obtained from both public sector and private sector providers. Payment was made on the basis of the principle of capitation. The per capita expenditure in 1999 was 1558 baht. Funds for the scheme are to be contributed by employees, employers and the government. Services were purchased from both private and public service providers. In the early 1990s there was a preponderant use of public facilities, but by the early 2000s the predominant providers were private service providers. The shift was largely on account of the Southeast Asian financial crisis—patients were less able to afford the high service rates of the private service providers, and as a result

such services were substantially underutilised. In this period, the private service providers became amenable to participating in the SSS on a capitation fee basis. With the passage of time, there was a drop in standard of services provided and corresponding dissatisfaction on the part of the beneficiaries—an average patient was not adequately informed to differentiate between the technically sound and inferior service providers. Coverage under the scheme in year 1999 was 9.4% of the population i.e. 5.8 million.

- **Voluntary Health Card Scheme**—This is a government-subsidised, voluntary health card scheme targeted at those in the formal sector not covered by the SSS, as well as those in the informal sector not eligible for the Medical Welfare Scheme (MWS). Services were obtained on the basis of payment of a capitation fee. Conceptually, this scheme has an interface with the MWS i.e. it took care of those wrongly screened out of the MWS. A survey made in the year 1996 showed that 27% of the enrollees were those with income below the poverty line. The scheme covered the enrollee and his family. The total coverage under the system was 14.2% of the population i.e. 8.7 million. Under the scheme the enrollee made a contribution of 500 baht, while the government made a contribution of 1000 baht. The average cost of services per beneficiary was found to be 534 baht. Looking to the average number of members in a family, the scheme is not financially viable

- **Private Health Insurance**—This is a voluntary, risk-related premium-based scheme catering to the well-endowed economic section. The coverage is limited to 3.3% of the population i.e. 2 million. The coverage is of two types – as an ‘add on’ to the life insurance policy; and, as an independent non-

life insurance policy. The premium rates are risk-related to the enrollees i.e. risk pooling is minimal. The average per capita premium for an ‘add on’ policy was 1917 baht, while that for an independent health cover was 1947 baht. This health insurance product has not proved to be financially viable. The loss ratio is very high (year 1997: ‘add-on’ policy - 0.89; independent policy - 0.63); and after adding the expense ratio and commission ratio, the operation becomes a loss-making one. Private insurance products cover inpatient services at private service centres. Mode of payment is ‘fee-for-service’. Possibility of large-scale coverage under this scheme is limited. The scheme is not likely to contribute to a substantial extent to the national goal of universal health coverage.

A break-up of the population covered under different health security schemes is given in the statement below.

Insurance Scheme	Persons (Million)	%
Civil Service Medical Benefit Scheme	7.40	12.0
Social Security Scheme/ Workmen’s Compensation Scheme	5.80	9.4
Medical Welfare Scheme	25.10	0.8
Health Card Scheme	8.7	14.2
Private Health Insurance	2.00	3.3
No Insurance	12.40	20.2
Total	61.40	100 (rounded off)

Source : Health Systems Research Institute; 2002; ‘Health Insurance System in Thailand.’

From the above it will be observed that 80% of the population is covered by one or other type of health security scheme. This is a fairly satisfactory situation compared to that existing in other countries in this region; and it can reasonably be expected that in the foreseeable future Thailand will achieve full universal coverage. For achieving the full-coverage status, the health security schemes would, no doubt, have to be somewhat restructured to correct the existing shortcomings and to obviate any mutual conflict between the different features of these schemes. The various existing health schemes reveal much variation in the costs and the span of cover offered. Gradually these would need to be brought into broad convergence in order to avoid overlapping, administrative waste and inefficiency between them. However it needs to be emphasized that the transformation of the schemes would have to be very gradual – as the funds available improve, the nodal insurance agency would be able to improve the scope of services in the more austere schemes, so as to increasingly align them with the broad features of the more liberal scheme. It needs to be highlighted that even for the more liberal scheme, which would be the CSMBS, the existing package of services cannot be said to be an extravagant one. However, during the period of implementation of the Universal Health Insurance Scheme there should be a complete freeze on the grant of additional concessions under the CSMBS.

At the current juncture the coverage of the health security schemes is not equitable over

the various income quintiles. A provincial health survey has indicated that in 1996 the un-insured in the different income quintiles ranged from 26% to 35%. The survey indicated that the insurance schemes were not particularly focused on the lower income sections. It was found the even the lowest income quintile (< 2000 baht) had 28% of its population uninsured under any insurance scheme. In these circumstances a substantial number of the poor risked impoverishment as a result of even single episodes of illness.

Summation

Taking an overview, the Thai health system is a fairly well developed and sophisticated health system with a larger part of the population of the country coming within its coverage. Expenditure in the health sector is ample. A large percentage of the population of the country (80%) comes within one or the other health security scheme. The various schemes are very varied in their scope as also span. Despite fairly high coverage of the population under health security schemes, access to health services to different economic sections is very uneven. However if the universal health coverage is to be fully achieved on a sustained basis some restructuring is still necessary. The experience of Thailand in designing its health system would be useful to other developing countries in designing their health systems.

V. Comparative Analysis and a Prescription for the Indian Health System

Financial Outlay

An adequate financial outlay is the most fundamental requirement for a viable healthcare system. A frequent complaint of the critics of the Indian system is that there are enormous inefficiencies and financial leakages in the existing health system. They, therefore, argue for improving of use of resources before making increased allocations. It would be futile to contradict the criticism of leakages, but equally it would be unfair to assert that these deficiencies are more pronounced in the health sector than in the other sectors of governance. Exploitation and self-serving manipulation of the system is a disease that is exacerbating the sectional iniquities plaguing our country. However, the allocations in the health sector are so miniscule that to begin the analysis by talking of wastage would not be a balanced approach. The argument of wastage is being used selectively for the collateral objective of turning off public funds from the social sectors. To say that the Indian community has to persevere to minimize waste - so that scanty resources are available for crucial public purposes—would be acceptable to all. Despite this position, there is no reason why enhanced funding in the social sectors should not be made available along with all concurrent efforts to minimize leakages. It is significant that we never hear the suggestion that resource allocations in the industrial sector be put on hold till the enormous diversion of funds seen in that sector, is moderated. It is common knowledge in the industrial sector that no entrepreneur of any standing would refrain from siphoning off (through over-invoicing of the price of plant, equipment and civil works), an amount less than the promoter's equity investment, even before the commissioning of the project. It is an economic reality that no high-

spending sector of the economy can be said to be free of the sin of diversion of funds to private pockets. It should be remembered that investment in the health sector directly meets the basic human needs of the citizenry and would warrant the acceptance of greater risks than that for state investments in trade and industry. After all, in the industrial sector profits are, in the first instance, earned to private account, and can only be linked more remotely to broad community welfare.

In the 1980s the desirability of public funding of projects was judged on the basis of a social cost-benefit analysis. That appropriate methodology has long since been discarded. However, even a cursory reflection would satisfy most that the social cost-benefit ratio in a struggling society is never better than for social sector initiatives.

Currently, state expenditure in India in the public health sector (0.9% of GDP) is less than half of that in Thailand (2% of GDP). **In monetary terms, the total health sector expenditure in Thailand is close to ten times that in India. India's public health expenditure figures in the group of five lowest spending countries in the world.** Indonesia's public spending, as also total health expenditure, is roughly of the same order as India, and both belong to the group of lowest spending countries in the world. The health system in both these countries is very inadequate and access to health services is by and large poor. **It is now universally accepted that a healthcare package has necessarily to be of a certain minimal size to make any impact. WHO's 'Commission on Macroeconomics and Health' has provided the best-deliberated conceptualisation of**

what can be considered an appropriate goal in the global public health arena. The report has estimated that a minimal package of essential interventions against infectious diseases and nutritional deficiencies could cost US\$ 34. This would substantially reduce mortality and morbidity burdens in the heavy disease afflicted countries. Thus, even the Commission set up by WHO has had to scale down its sights from the goals of the Alma Ata declaration. It is apparent that the minimal package recommended by the Commission is an attenuated version of comprehensive healthcare for all. For obtaining resources for meeting such a goal, it has been proposed that countries raise the public health outlay by 1% of GNP by year 2007 and by 2% of GNP by year 2015, while the developed countries should pitch in by contributing US\$ 22 billion by year 2007 and US\$ 31 billion by year 2015. Currently the quantum of global funding to the health sector of under-developed countries is of the order of US\$ 6 billion per year. As a part of the holistic package of globalisation, the consensus amongst developed nations appears to favour a substantial and increasing contribution from this group to the health sector of high disease burden countries.

The Common Minimum Programme (CMP) of the United Progressive Alliance Government has committed itself to a goal of raising public health funding to 2-3% of the GDP. If this is attained it would constitute a landmark achievement. It is obvious that any such ambitious target would require that the increase be phased over the five-year life of the government - we cannot restrict ourselves to small increases in the early years in the hope that there would be a spectacular leap in the last year. The capacity for the state administrative apparatus to gainfully absorb funds would have to be built up over the years, otherwise increased leakages and wasteful expenditure would be the inevitable outcome. The resources allocated so far in the first three years

of the Tenth Five Year Plan have been Rs. 19,552 crores. This was too small to instil confidence amongst the citizens that the state was serious in its declaration of substantially increasing its resource commitment to the social sectors. However, the Budget of 2005-06 has made a substantial increase with an allocation of Rs. 9649 crores. – with this the aggregate allocation of funds in the first four years of the Tenth Plan would rise to Rs. 29,201 cores as against a Tenth Plan outlay of Rs. 37,153 crores'. This development raises hopes that eventually the funds made available in the course of the Tenth Plan would substantially exceed the Plan outlay. In any case if the government is to realize its goal under the CMP-of increasing the public health outlay to 2-3% of GDP – the future budgetary allocations will have to be much higher than the current scale of allocations. Consistent with this picture, it would be necessary for the government to increase the outlay for the health sector in the remaining years of its tenure by at least 35% each year, to have any chance of achieving the goal. If the aforementioned goal is to be brought to fruition, government will have to cease treating the allocations to the social sectors as 'sops'. Considering the ripple effect of community benefits, it would be appropriate, if in spirit, government treats budgetary allocations to the social sectors with exactly the same sanctity as they treat 'charged expenditure' under the Constitution.

Decentralisation of the Health Administration

The experience of both Thailand and Indonesia highlights the handicaps suffered on account of over centralisation in the health sector. In both these countries most of the powers were concentrated, not even at the provincial level, but at the more distant national level. The administrative distance

between the level where the scheme/funds originated and the sub-centre where they were implemented in the form of delivered services was inordinately long. The field operations at the decentralised level thus, virtually remained unsupervised. Both these countries have undertaken an intensive exercise in decentralisation. Thailand is at an advanced stage of implementation of the decentralisation plan, while Indonesia has completed its conceptual exercise and is on the brink of the launch of the programme. In India the health administration is pivoted at the state level, though several schemes, and about 25% of the resources, are allocated from the centre. The field public health organizations in the country are the state public health organizations - at the apex of the pyramid is the state health department, and below that sequentially are the district health offices, community health centres, primary health centres and the sub-centres. In order to reduce the time spent on administrative processes the central government had for some schemes initiated the practice of releasing funds directly to the district administration, or to autonomous societies/trusts located at the district level, without involving the state administration. This naturally reduced the administrative distance between the central government that funded the scheme and the decentralised entity executing the scheme, and process time was considerably shortened. However such administrative procedures have no mechanism for exercising supervision over the activities at a reasonably proximate distance. **In some experiments of this type in India, it was found that the state public health department came to be entirely by-passed and the scheme, in a sense, became orphaned. This seriously affected the quality aspects of the programmes under implementation. To avoid a situation in which supervision becomes weak, it is necessary to ensure that the technical and administrative supervision be entrusted to the state level, even as release of funds and auditing of accounts may by-pass the state government.**

In India it would appear advisable to delegate the greater part of the administrative and financial powers to the decentralised block, tehsil and district levels. The 73rd and 74th amendments to the Constitution have already laid the legal foundation for such initiatives. Like Indonesia, India has also given fiscal powers to the lower tiers of local-self-government institutions, encouraging these decentralised levels to raise resources for their felt needs. In fact, one may perhaps, even say that too much reliance is placed on the capacity of the decentralised levels to raise revenue. **A word of realism needs to be introduced here. Raising of revenue is not a popular initiative at any level of the government or quasi-government institutional structure. At least in the initial stages, substantial resources cannot be expected from that level as a replacement of central budgetary funds. Therefore, if the central budgetary support is switched off at short notice the development activities may come to an abrupt halt, thereby bringing the entire process of decentralisation into disrepute.**

In the matter of planning for the health sector at the decentralised level a cautionary comment would be in order. Field activists often place unqualified confidence in the capacity of a decentralised entity to independently draw up a unique health sector plan appropriate to its domain. There is often a tendency to romanticise the actual capacity of decentralised entities for planning and implementation of schemes. Since the alternative - centralised planning - has proved to be such a failure in the past, as a backlash, uncritical confidence is placed on the capacity of the smallest decentralised entity. While the socio-economic features and the sensitivities of each decentralised entity need to be assimilated in the process of drawing up a macro-area plan, each decentralised plan needs to be positioned within the contours of a macro technical framework. By

way of illustration, in a malaria-affected area one village may well decide to discontinue expenditure on anti-malarial spraying operations since the incidence of malaria had been moderate in the last few years. In an area where the risk of multiplication of malarial mosquitoes is high on account of various geographical, climatic and other environmental factors, the localised discontinuation of preventive measures against the vector would not only endanger the village in question, but also the entire area that is malaria-prone. **Unilateral decisions at decentralised levels may not be very rare as a sound understanding of the basic principles of public health is not as widely available amongst the citizenry as is sometimes taken for granted. Thus, in practical terms it would be best if the decentralised entities are given the freedom to accommodate their local needs and unique perceptions within a broad, technical macro-plan formulated at the state level.**

Health Status

Though the health status of India has improved greatly since independence, for most health indicators we are still far from acceptable levels. The IMR (a key health indicator) for India is 335% that of Thailand and 176% that of Indonesia; the MMR for India is 4200% of that in Thailand and 160% that of Indonesia; and in respect of life expectancy, India at a figure of 65 years is 3 years less than Indonesia and 8 years less than Thailand. What is even more worrisome is that the tempo of decline of IMR has slowed down in the two decades (1980's and 1990's) and today it is near stagnant. While in no way can we currently hope to compare ourselves with Thailand, it is a matter of considerable embarrassment that we even show up poorly in comparison to Indonesia, which is only a struggling developing

country. Even for the historical, pre-transition diseases, the disease burden in India is very high. The National Tuberculosis Institute/ Tuberculosis Research Centre, Chennai's Study - 'The Annual Risk of Tuberculosis Infection in different Zones of India' - has estimated the ARTI (Annual Rate of Tuberculous Infection) in the country as 1.5%. This means that about 15 million individuals acquire new Tuberculous infection every year, with a minimum of 0.75 million cases progressing to smear positive, pulmonary TB cases per year. This is in addition to the existing load of 15 million active TB cases; about 0.45 million TB afflicted are estimated to die every year. By way of comparison, the current ARTI in most developed countries is of the order of 0.1%. India's pool of TB infected persons is more than 30% of the global pool.

In respect of incidence of malaria in the country, there is no accurate estimate but individual assessments of knowledgeable public health specialists would put the number at not less than 10 million cases per year. There is again no accurate estimate of the annual incidence of water borne diseases like gastroenteritis and cholera, but no one would dispute a general statement that the seasonal disease burden is very heavy. These diseases, as also other communicable diseases, take a heavy toll of the well being of our citizenry despite the fact that preventive regimens, as also curative drugs, are very inexpensive. The unfortunate conclusion from this account is that a large number of citizens suffer needlessly as they do not have access to health services, whether private or public, even for the more common diseases. As one of its priority objectives the country must try to correct this situation.

Role of the State

Any self-respecting State in this day and age, at least in principle aspires to implement some

form of universal health coverage for its citizens. Thailand has achieved health coverage for 80% of its population and is rapidly advancing towards universal health coverage. Indonesia has drawn up its plans for a nation-wide social health insurance scheme and is on the threshold of launching it. India also aspires to attain that status, though unfortunately its plans are still in their infancy. The modality of a typical social health insurance scheme has features that would make it viable and implementable in our country. However looking to the circumstances prevailing in the country, it has to be recognised that this would involve a substantial role for the state - by way of enhanced funding; and through enforcement of statutory monitoring, evaluation and control procedures over various facets of health insurance. The areas that would require supervision and control, inter alia, include: notification of the tariff for the premium; registration of service providers; notification of treatment protocols; operation of a system for quality audit of services; operation of a mechanism for fixing capitation fees to be paid to service providers; mechanism for crediting the state subsidy to the health insurance scheme; etc. **Looking to the responsibilities that will devolve on the state, it would seem that the role of the state would increase and not decrease with the introduction of social health insurance. However these responsibilities would be significantly different in nature from its current responsibility as a direct health service provider.**

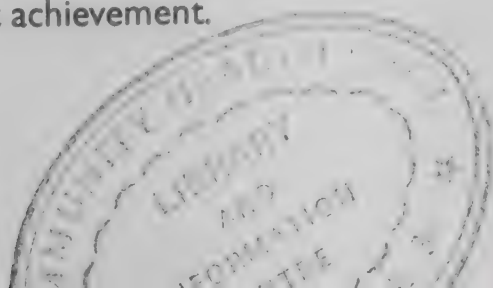
The broad break-up of the current health expenditure is: 17% public funding; and 83% private funding. Looking to the marked skew in the expenditure, there is clearly no escape from increasing the public spending share in the foreseeable future. If the United Progressive Alliance Government fulfills its promise of raising public health expenditure to 3% of GDP, this would be a great achievement.

Equity in Access to Health Services

The universal availability of a defined package of healthcare must be adopted as a basic human right to health. This package must be provided by the State to its citizens in discharge of its fundamental duty. The mere availability of financial resources in the health sector does not necessarily constitute sufficient discharge of the State's duty. This position is starkly evident in the USA - with a per capita health expenditure that is eight times India's per capita GDP, 40 million American citizens are still without any health insurance cover. The health system in Thailand also provides similar evidence. Despite a total health expenditure in Thailand which is 6 times that in Indonesia and India, the statistics of access to health services show as much of a skew between different economic sections, as is seen in India and Indonesia. A survey revealed that for the year 1997, for different income quintiles the percentage not covered by any health security scheme ranged from 26% to 35%. It was also observed that the health services were not well focused on the lowest income quintile - 28% of the lowest income quintile was not covered under any health security scheme. It has been observed that the poorest quintile spent 4.2% of their income on healthcare while the richest quintile spent 1.2% - a 3.4 fold difference.

The distribution of infrastructure and medical manpower in Thailand is very uneven—it is largely concentrated in Bangkok and its hinterland. Thus, despite substantial availability of resources in the national health system, one of the major objectives of universal health coverage—equity in access to health services—is still a distant dream.

Turning to Indonesia now, the situation in regard to equity in access to health services is as unsatisfactory as in Thailand. Indonesia has experimented with a variety of community-based health security schemes



HP-120
09228 P06

that normally can be expected to improve equity in access to health services. Despite that, access to health services continues to be very uneven between different economic cohorts. Statistics of reported illnesses/service utilisation show that the lowest quintile has markedly less access to all categories of services except outpatient services. It is also observed that the access to high-cost private services is much more for the highest consumption quintile than the lowest quintile—four times in the case of specialist services and seventeen times in the case of hospital services. The highest income quintile captures 29% of the public healthcare subsidies while the lowest income quintile accesses 12% of the subsidies. Also, 8% of the highest income quintile goes untreated on account of lack of access, while as much as 46% of the lowest quintile goes untreated. From these facts it is clear that Indonesia is still a long way from making basic healthcare available to its vulnerable population. The experience of this country clearly shows that merely designing community-based health financing schemes is not enough unless it is ensured that financial barriers do not persist in blocking participation, and the scheme has a service package of reasonable size that provides a modicum of health security. Finance Ministry functionaries often have a woolly conception of community-based social sector schemes, expecting that such participatory activity will obviate the need for large scale funding. Any field activity will need a minimum critical mass of resources. When these become available, the efficiencies inherent in a community-based organizational structure will come to the fore, ensuring optimal results. However, if domestic financial barriers prevent the ordinary people from raising that minimum critical mass of resources, or from organising an appropriate span of operation, the state has to intervene. Over decades Indonesia has experimented with a variety of community-based schemes—Posyandus, Dana Sehat, Bapels etc.—where the contributions affordable to many participants was so meagre (sometimes the equivalent of a few paise in Indian currency), that no

service worth the name could ever be organised. Unkind critics sometimes assert that, from time to time governments float utopian schemes only to avoid the immediate commitment of resources for the health system; in other words the allegation is that the state abdicates its responsibility. While such a statement may be somewhat harsh, the fact is that the mere designing of community-based health services cannot be a substitute for resources; at best, well-designed ones can create efficiencies in the use of resources. The lesson for India from this experience is that the state must be prepared to underwrite substantive resources for any social health insurance scheme over the foreseeable future. In the longer run, with economic growth the capacity of the citizens to contribute towards the scheme can be expected to improve, and with that, the burden on the state would taper off.

Public-Private Mix of Services in India

It has been highlighted earlier that the health services in the country have been abnormally skewed in the direction of the private sector. The emphasis of this monograph so far has been that the aggregate volume of health services would have to be increased over time in order to have some impact on the condition of the vulnerable section of society. The current conventional wisdom seems to require that only the private sector should be relied upon, as in the past, the public sector has shown little capacity in meeting the health needs of the country cost-efficiently. It would not be correct to jump to a conclusion on impulse — for any claim to objectivity, we must examine the evidence available. One widely prevalent criticism is that the public health services are not correctly focused on the lower income categories. Reliance is placed on a World Bank-sponsored study carried out on the basis of the data collected in the 52nd Round of the National Sample Survey Organisation (NSSO). Annexures I'-II contain the relevant statistics

broadly speaking the conclusion of the study is that public health curative expenditure is unambiguously 'pro-rich.' It is asserted on the basis of this study, that the higher consumption quintiles utilise the services more than the immediately lower quintiles in the case of both public and private facilities. An eye-catching conclusion often cited from this study, is that the highest quintile uses over three times the quantum of public services (i.e. subsidy) used by the lowest quintile. A close examination of the statistics would, however, indicate that a very large part of the public health services are, indeed, utilised by those below the poverty line, or those only just above it. India's per capita consumption pattern is very heavily skewed towards the low-end consumption levels. In the study that has been mentioned above, dating to field data of the period 1995-96, the mean consumption figures for the successive consumption quintiles are Rs. 2169, Rs. 2973, Rs. 3698, Rs. 4723 and Rs. 8123 per annum, respectively.

The All-India cut-off for the poverty line for the same period is a consumption figure of Rs. 3879 per capita. Thus, as per the NSSO study, the mean consumption figures of the first three quintiles fall below the poverty line and most of those citizens coming in the other two consumption quintiles are only just above it. This is not surprising, as it is commonly known that only a small section out of the country's population can really be called the 'rich'. Thus, the observation that the higher quintiles access more of the health services than the next lower quintile (and more dramatically stated: that the highest quintile accesses over three times the quantum of services as the lowest quintile), is exaggerated, and is not as significant as is made out. **On the basis of the data it would be excessive to assert that the 'rich' pre-emptively appropriate the public health subsidy. Given the consumption range of each of the quintiles, the reality is that much of the public health services are availed of by the persons belonging to the lower four quintiles, who are, for the larger part, either below**

the poverty line, or only just above it. These beneficiaries come within the broad category of 'economically backward'.

It has been observed that within the category of the 'economically backward', the higher consumption cohorts get better access to health services than lower consumption cohorts. This is only to be expected. Each marginally higher level of consumption brings with it an additional quantum of social empowerment. Within the 'economically backward' category the lowest consumption cohorts would indeed be hard put to access even minimal nutrition, leave aside their capacity to access healthcare services. This inference is also consistent with the common perception that, given the poor quality of public services, it is unlikely that many of those who can afford the private facilities would still choose to aggressively corner public health services to the detriment of the claims of the poor. The poor quality of public health services itself limits the demand for it. Greater focus in the delivery of health services can only be brought about through more stringent administrative screening. The section of the population that is least empowered to navigate through the administrative maze is the lowest economic quintile. Therefore any resort to more stringent screening would in fact, screen out that very section that is most deserving of subsidised healthcare, the opposite of what our objective is. **In sum, it can be said that the public health services are reasonably focused on the needy and further attempts to focus on the poorest would only be counter-productive. Also, the statistical data does not justify a hatchet conclusion that public health services are not well focused on the poor, or even worse, that public health curative expenditure is unambiguously 'pro-rich'.**

Another interesting feature of the NSSO data is that it does not reveal any significant gender bias against females in the utilisation of healthcare services/subsidies. It is observed that in respect of reporting

of ailments/treatment of ailments, females do as well, if not better, than males. Utilisation of public health subsidies is higher for females in all but the highest quintile. However, the per episode expenditure for inpatient/outpatient treatment is more for males than for females. This would imply that, while the access of women to healthcare services is not restricted, perhaps there is more of a tendency to 'skimping' in the case of women than in the case of men. Such overall statistical trends are contrary to common perception and seem to indicate that the handicap suffered by women is on the decline. **While one would hesitate to make any categorical assertion based on the data, perhaps a cautious hypothesis can be suggested that the public health system operating in the country has been successful in moderating the historical bias against women in accessing healthcare services.**

While much has been said about the limited reach and indifferent quality of public health services, the discussion in the previous few paragraphs will indicate that, despite the shortcomings, the public health service has inherent strengths and has contributed to the delivery of health services to the vulnerable section. Quite often when discussing the Indian health system, this aspect gets ignored.

Another aspect that would have to be taken into account in choosing a particular public-private mix in planning additional healthcare services for the country, would be that of relative costs of these two types of services. Several studies have shown that the cost of private services, both inpatient and outpatient, is substantially more than that of corresponding public services. **In a range of health economics studies private outpatient services have been found to be 20-54% higher, while inpatient services have been found to be 107-740% higher. No known study has shown the private services to be less expensive than public services.** Thus, while deciding on a private – public mix for services

the distinctly higher cost of private services would be one relevant consideration.

India seems to be moving in the direction of some variant of a social health insurance scheme in its quest for universal health coverage. All past global experience indicates that the growth of this scheme would be gradual and would be spread over several decades. The current availability of health services in the country is scanty and poorly distributed. With the exacerbation of this situation on account of the early-stage impact of globalisation and liberalisation, alternative modes of health service delivery would also have to be tried, even as the social health security scheme is gradually introduced. The distribution of the existing private healthcare delivery facilities is already heavily skewed towards the urban centres. Thus, the state initiative in the foreseeable future would have to be in the area of primary health services in the remote rural areas. Scattered projects run by NGOs have proved that it is possible to provide quality primary sector healthcare at surprisingly low costs. While some of the intangible strengths of voluntary organisations, like high motivation, solidarity of the participating community, etc., cannot be expected in the same measure in public sector activities, the evidence indicates that fairly good quality services could be delivered at a reasonable cost even in the latter category.

Structure of the Public Health Organisation

Quite often during discussions on the health scenario in India, the point is asserted that the existing organisational structure is not suitable. This claim would need closer scrutiny. The structure of the public health organization is a four-tiered, pyramidal one with the state health department at the apex and the sub-centres at the base. Indonesia has a similar organisational structure. In both India and Indonesia primary health centres/community health centres

cover a normative population of 30,000. Below this are the sub-centres covering a normative population of 10,000 in India and 5,000 in Indonesia. The lower norm for a sub-centre in Indonesia is understandable as the country consists of around 6,000 inhabited island entities. Even under the existing norms in India the infrastructure is much below the normative entitlement. In the circumstances there would be little point in liberalising the norm even more. However in hilly regions that face logistical problems, as also in the few island entities existing in the country, the norms would need to be relaxed. Apart from this, the existing norm for a sub-centre covering a cluster of ten large villages, and that for a primary health centre covering twenty five clusters of such villages, would not be an inappropriate one, at least for the time being. The network of service centres at different tiers, with manpower and equipment as per the norm, would give the public health system adequate capacity to discharge its functions.

The adoption of vertical field structures has been adversely commented upon by some academics, as also by the multi-lateral funding agencies. The criticism is that this distracts attention from the normal broad-based primary sector healthcare activities and does not create the right conditions for all-round public health services. However, in the past, it was the view of the central government (as also of the present writer, if that adds weight to the view!), that despite serious negative features in the vertically integrated structure, in the medium term there is no escape from them. **Given the health scenario existing in the country, with an enormous burden of some diseases, it would seem to be beyond the capacity of the conventional public health organisational structure to bring down to a moderate level the burden of these diseases, at which stage the conventional organizational structure could take over the implementation.** The vertical field structure is particularly suitable for a disease when its eradication is a viable public health goal (e.g. polio, small pox,

leprosy and guinea worm). However, while saying this, it is always recognised that the vertically integrated structure is not financially sustainable in perpetuity. As the burden of disease is brought down over time, the disease-specific organisational structure can be wound up and the ongoing responsibilities can be transferred to the standard public health organization. This integration has already been initiated for the Leprosy and Cataract Blindness Eradication Programmes. Also, it merits mention that the vertically integrated programmes have proved to be reasonably successful in the field. Leprosy is close to elimination level; the pool of bilaterally blind (on account of cataract blindness) has greatly reduced and all programme targets have been exceeded by large margins; the time-trend of estimated HIV-AIDS cases in the country has shown a plateauing out, indicating a modicum of success in one of the most difficult challenges faced in the history of public health; and the National Tuberculosis Programme by adopting the 'Directly Observed Treatment, Short-Course' Strategy (DOTS), has shown remarkable results, both in terms of numbers and quality, in its area of coverage. **These examples provide good evidence that the vertically integrated programmes have been worth the greater cost and effort required for them.**

Cost-Effective Healthcare

All over the world, including resource-deficit developing countries, there is a marked trend towards high-tech, and therefore high cost, medical services. This is observed in both public and private sectors, though it is more pronounced in the latter category. More specifically, the share of expenditure in the tertiary sector is increasing, at the cost of primary sector healthcare. The impact of this trend is naturally felt more by the poor—on an average the poor spend 12% of their income on healthcare as against 2% of the income by the rich. For India it has been estimated that in 1998-99 the primary sector expenditure was of the order of 42% of total health

expenditure. The National Health Policy-2002 has set a target to increase this to 55% of the total health expenditure. It is well accepted that primary sector expenditure, which inter alia includes, preventive and promotive initiatives, is the most cost-effective. Despite this, high-tech treatment regimens and other inappropriate procedures are being pushed forward, largely driven by the commercial interests of the pharmaceutical sector. The tendency is more marked in the private sector – studies show that the costs of both inpatient and outpatient services is much higher in the private sector as compared to the public sector. The immense possibilities of cost-efficient primary healthcare initiatives have been demonstrated by several NGOs operating in the field. The trend towards high-tech, high-cost services are observed in Thailand and Indonesia too. In Thailand during the nineties there has been a proliferation of private hospitals. However these did not attract enough business from the privately paying patients. In the period 1995-99 the bed occupancy of private hospitals was only 40% as against 83% for public hospitals. In the period 1980-2000 the average growth rate of per capita health expenditure was 8.2% as against an average economic growth rate of 5.8% of GDP. This is another indication that health services were becoming more expensive because of use of costlier technology. The above observations on the trend of health expenditure make it clear that a concerted effort is needed to hold down the cost of health services. One way of bringing this about would be to ensure that a higher percentage, say 50% of health expenditure, is State-funded; this would have a moderating influence on the entire health market. The State funding suggested above is not on an extraordinary scale-even developed countries choose to spend large amounts of State resources, both as a percentage of the total health expenditure and in monetary terms. In UK almost the entire health expenditure is State-funded (US\$1357 per capita); while in USA the State contributes US\$1857 per capita (45% of the total health expenditure). Most other developed countries contribute a higher

percentage of State spending in the health sector than the USA. Juxtaposed to this is the fact that the number of poor in India (below the poverty line) is as large, if not larger, than the population of the USA. It would be a long time before the State could, in good faith, think of withdrawing from the health sector. **Given these circumstances, the State spending in India should not only be increased in monetary terms but should focus squarely on a basic package of primary healthcare. The curative portion of the package should only contain items from the essential drugs list, which in turn must be mainly from the generic domain – even branded-generics must be excluded.**

User Charges

In the spirit of decentralisation and liberalisation of the public health system, in some states the secondary sector service centres have been granted substantial operational autonomy. The autonomous institutions have in turn introduced user charges for various clinical procedures. The experiment made in this direction in Madhya Pradesh is particularly deserving of mention. The management of the centres has been entrusted to autonomous entities - Rogi Kalyan Samitis - with the participation of people's representatives, health department functionaries and major donors. This organisational rearrangement is seen to have improved the operational efficiency as a result of a new sense of ownership established amongst the stakeholders. The revenue collected through this initiative is meagre, but the consolidation of the feeling of ownership amongst the beneficiaries, is a valuable spin-off. While noting this people-friendly initiative, the experience of Indonesia would offer valuable operational pointers. In Indonesia many of the autonomous service centres in their enthusiasm for raising revenue, fixed user charges at unconscionably high levels. As a result, many of the needy patients came to be screened out of the reach of services as

they could not afford the user charges; even amongst those with better financial capacity, the patients often turned to cheaper private service centres where quality of services was better. As a result, public service centres came to be under-utilised despite having adequate capacity, and the really needy lost access to any type of health service. The management of such autonomous service centres need to be sensitised that user charges are never intended to be a substitute for state funding of public health services. These are merely nominal charges that give the management of the institution a small kitty of funds for use in a flexible manner, untied from rigid budget lines. As a costless bonus, the system of user charges generates a wholesome feeling of fellowship amongst the beneficiary community resulting in better supervision over the institution and greater efficiency. Thus, the system of user charges is an unobtrusive way of changing the ambient work culture in public service centres, thereby increasing their efficiency and acceptability.

Social Health Security

In India currently only about 11% of the population is covered by any type of health security scheme. In Indonesia the population covered is 13.8%, while, as mentioned earlier, in Thailand the population covered is 80%. If the goal of universal health coverage is to be realistically tackled, both Indonesia and India will have to take giant strides in the direction of implementation of health security schemes. India currently has five different types of health security schemes (CGHS, ESIS, community-based insurance schemes, employer-based insurance schemes and private health insurance schemes). The fact that between them, these five schemes cover only 107.4 million people shows how small the pool is under each one of them. With such small pools the schemes do not have the essential features of an insurance structure that would result in economies in operation. Four of these schemes (CGHS, ESIS, employer-based

insurance schemes, and private insurance schemes) cater to the relatively better off sections of society. In all the schemes, the most vulnerable section consisting largely of the rural under-employed/unemployed, are not covered. By their nature these schemes cannot expand to promote universal health coverage. The private insurance schemes are particularly exclusive in nature, covering only the low-risk group with high cost services. In fact, the private insurance schemes do not resemble a typical insurance scheme and are more in the nature of dedicated healthcare savings schemes. The serious shortcomings in the Indian health security initiatives will have to consciously avoid the above-mentioned limitations in the pursuit of universal health coverage. The main challenge to the Indian health system is to aggregate the currently expended quantum of out-of-pocket expenditure, along with the requisite additional contribution of State resources, to provide a modest package of health services through the institutional pooling of both resources and health risks. In the recent past India seems to have taken its first steps towards a state-designed, universal health security scheme. In the budget of year 2003-04 the government introduced a Universal Health Insurance Scheme (UHS) funded by employee and employer contributions; the government also provides a subsidy for BPL beneficiaries. In the next budget (2004-05) the government announced pilot projects under the 'Unorganised Sector's Workers' Social Security Scheme' (SSS). Both these announcements are early signals of government's intention of bringing about universal health coverage for the workers' of the unorganised sector. It may be mentioned that the SSS, besides offering an old age pension and a personal accident insurance cover, also provides a health cover similar to the UHS. Basically, the health security scheme covers a limited reimbursement package for inpatient hospital services. Funding for the scheme is from the contributions of the employee and employer; government contribution is small and is limited to BPL beneficiaries. The scheme, as initially structured, appears to be financially non-viable. The large-scale

participation of workers from the unorganised sector seems unlikely on account of the employees' inability, and the employers' disinclination, to pay.

The Indonesian experience provides similar lessons of non-viability of health security schemes with inadequate State support. Over its history the country has tried out seven types of community-based schemes – *Posyandus*, *Dana Sehat*, *ASKES*, *Jamsostek*, *Bapels*, *Pre-Bapels*, and private health insurance schemes. These have suffered from a variety of shortcomings. *Posyandus*, *Dana Sehat*, *Bapels* and *pre-Bapels* had very small pools and a very low premium contribution. As a result, there was minimal pooling of risk and the scale of reimbursement was so small as to provide little financial security. *Jamsostek*, because of the exemption provided to business entities, constituted too small a pool for acquiring the features of a mature insurance scheme. In sum, the Indonesian experience teaches us that the coverage must be large-span, and the premium payment schedule must not be unrealistically low. When financial incapacity does not permit private contributions to be raised, state subsidy is a necessity in ensuring the viability of the scheme.

The Thai experience also highlights the handicaps faced on account of the creation of sub-optimal sized risk pools. Thailand has five types of health security schemes (MWS, CSMBS, SSS, VHCS, and voluntary private insurance). Each of these is small in span—the largest, the Medical Welfare Scheme, having coverage of 25.1 million. Also, the principle features of the schemes are not identical. The scope, quality and cost of the schemes varied widely – the cost ranged from 363 baht per beneficiary to 2106 baht per beneficiary. To ensure that the schemes remained sustainable over time they would be required to converge on a basic healthcare package. As the situation exists, the variations in the features of the schemes encourage competitive pressures for relaxation and modification of the schemes to obtain more liberal benefits. An estimate made by the Thai authorities showed that

the universal health insurance programme would cost 100 billion baht in the year 2001. This works out to a per capita expenditure of approximately 1640 baht. In this backdrop, only the CSMBS would be significantly more expensive than the above average, while several of the schemes offer a much more modest quantum of services. The practical approach would be to design a package of services costing around 1500 baht per capita, and in gradually ensuring that all the existing schemes come in line with the designed package. For most of the beneficiaries under the existing schemes this would mean a substantial improvement in health services. Even for the CSMBS beneficiaries, with the improved cost-effectiveness on account of the larger scale of operations, the dilution of health care services may not be significant. **The lesson from the Thai experience is that financial sustainability would be ensured fairly easily if the different health security schemes were brought to converge on the adopted outline of a common basic package of services.**

When attempting universal health coverage under the modality of social health insurance, the question as to who will be the service provider, has to be addressed. There seems to be a broad acceptance of the position that it would be impossible for the state to provide services for the entire population of the country. On its present scale the state delivery system seems to be too large and overstretched. Also, the state is expected to increase its presence as a provider in the health sector, till such time as the social health insurance scheme has expanded and stabilized. Given the inherent difficulties in managing gigantic field organisations, an alternative, worth examining, is the use of private health service facilities for delivery of healthcare at state expense. There is a large quantum of private health service capacity in selected urban areas of the country that are relatively underutilized. The state could co-opt these private service delivery centres into the social health insurance schemes. This would of course have to be at competitive capitation rates. Such an approach of co-opting private

service providers has been attempted in Thailand and Indonesia, and to a small extent under the CGHS in India. As has been learnt from the experience of Thailand and Indonesia several issues will have to be tackled in the course of implementation of social health insurance. These are discussed hereafter.

- An economically designed, standard package of healthcare has to be finalised and uniformly adopted by all health insurance schemes. This should consist of preventive, promotive and curative initiatives in the primary sector, and inpatient treatment in general hospitals in the secondary sector. If any health insurance schemes wish to offer a more elaborate package, this should only be permitted as an 'add on' to the standard basic package. The promoters of health insurance schemes generally appear more enthusiastic to cover inpatient healthcare rather than primary sector healthcare. This is because the management of the former category of schemes is simpler—obtaining services from a limited number of inpatient service centres is more easily manageable. However, insurance schemes covering hospitalisation services only would have relatively limited potential and the coverage under such schemes can never be very large or viable. Despite the many more administrative complexities, insurance of inpatient services is best combined with primary sector healthcare coverage. Primary sector healthcare includes preventive and promotive measures, combined with inexpensive ambulatory care. These health initiatives are very cost-effective. More than 75% of the expenditure incurred by the individuals is on minor ailments. The small amount expended on these minor medical disorders results in avoidance of complicated disorders and saves much larger expenditures in the secondary and tertiary sectors. In this backdrop, a health security package

containing a substantial element of primary sector healthcare would reduce the burden of expensive treatment at the secondary/tertiary levels.

- Universal health coverage in India will be achieved by gradual modification of the five existing health security schemes so as to make them converge on a desired module. The features of the existing schemes, which are more liberal, would have to be frozen. The more austere schemes would gradually be brought in line with the adopted health security module. A problem is likely to be encountered in the case of the Central Government Health Scheme (CGHS) that offers a very wide range of medical services. While these facilities may in reality not be available to most beneficiaries, this would nevertheless give the group an excuse to protest about the whittling down of the theoretical span of the scheme. The only practical way of bringing the CGHS in line with the adopted health security module would be to compensate the CGHS members in an ad-hoc manner, separate from the health entitlement. While the aggregate expenditure to the state would be unchanged, at least the health security scheme for government employees would be in conformity with the standard health insurance module, and the ground would be ready for large scale pooling of beneficiaries under the standard health insurance scheme. In the transition, no new benefits are to be granted under the CGHS—in fact, over time they must merge in the nationally adopted insurance module.

The primary healthcare package adopted for universal health insurance would need to be a modest one if it is not to become unaffordable. Currently it is estimated that the state is spending Rs. 90 per capita per year for primary sector healthcare (i.e. 42% of the total health

expenditure). With this in the background, the scope of the primary healthcare package needs to be accommodated within a per capita cost of, say, Rs. 150. This limited package can be gradually introduced over the years to an increasing population pool, eventually covering 500 million persons at the end of a period of five years. This would require additional resources of the order of Rs. 3000 crores per year for a population of 0.5 billion, which should easily be accommodated within the government's target of providing 2-3% of GDP as state funds by the end of the current term of the government.

- The mode of payment to service providers has to be determined. Some countries have a 'fee-for-service' modality, while others have adopted a 'capitation fee' modality. The former has proved to be very inflationary. Thailand, which has largely adopted this mode, has witnessed a huge surge in the health costs, much more than the rate of growth of the GDP. The 'fee-for-service' mode does not allow effective control of expenditure. The service provider is keen to maximise the treatment procedures and treatment regimens in order to benefit financially, and the patient is indifferent to the consequential increase of costs. The 'capitation fee' mode involves payment of a fixed amount per capita, and the service provider is required to treat the patient as is necessary. This mode of payment is more economical and inhibits unnecessary and wasteful treatment. The service provider would not like to spend money for a procedure that is not necessary, and yet the patient would have to be given reasonably effective treatment, or he would shift to another provider with a better reputation. The 'capitation' mode of payment requires that a mechanism be established for fixing a reasonable annual fee per capita—if the

fee is too low the private service providers would not volunteer to register under the scheme, or having registered, would offer sub-standard services. On the other extreme, an excessively high rate of 'capitation fee' would bleed the scheme and would render it financially unviable in the long run.

- The administration of the insurance scheme has to register service providers having the requisite manpower and infrastructure. The distribution of the locations of the service centres would have to be such as to enable all participants to approach a service centre in time of need, within a reasonable distance. The performance of the service provider has to be evaluated on a continuing basis; sub-standard service providers would need to be weeded out. A grievance recording procedure for the beneficiary would also have to be set in place.

Skill-Mix Amongst Doctors

The availability of doctors per million population in the three countries studied is as follows: India—1000; Indonesia—155; and Thailand—290. The Indian figure includes practitioners from all systems of medicine. If one were to only consider the trained doctors under the allopathic system, which is the preferred system, the availability would be much lower. 85% of the doctors are in the private sector. The world average for availability of doctors for low-income countries is 1000. Thus India does meet the norm at the national level, though severe mal-distribution results in large sections of the population having no access to trained doctors. In all the countries under study there is a marked tendency for the medical graduates to go in for clinical specialisation. In India at this juncture, the number of post-graduate seats available in clinical specialisations is 39% of the total number of doctors graduating every year. This is clear evidence

of excessive emphasis on clinical specialisation. In Thailand the clinical specialists are about 55% of the total number of doctors, which is again excessively high; the number of clinical specialists in Indonesia is about 17%, which can be considered reasonable. **As a result of this imbalance between clinical specialists and general practitioners, the conventionally adopted treatment regimen in India and Thailand has a tendency to be specialist-dominated, and there is a marked paucity of general physicians. 'Family Medicine' is generally not treated as a useful area of specialisation; and 'Public Health' is a specialisation of last choice.**

It is amazing to find that in the central government's cadre of doctors (Central Health Service), with strength of about 4700 doctors; only 78 have post-graduate specialisation in public health. The need for public health specialists is acute in the national health system, and the lack of quality in outpatient services can only be attributed to the paucity of experienced general physicians. A major component of public sector health activity is in the area of promotive and preventive initiatives. These activities are very cost effective and are of a type that is not likely to be substituted by private sector initiatives. Thus, these activities become the exclusive responsibility of the public health discipline. The pool of government doctors in the country consists, for the larger part, of ordinary medical graduates, with a small number of specialists mainly in the clinical disciplines. The graduate doctors, for the larger part, become routine administrators and only a few discharges the role of efficient physicians. The best of the specialists are indeed top-of-the-line and tender valuable service in the secondary and tertiary service centres of the public sector. However, it is noticeable that very few of the government doctors are either specialised in, or are mentally attuned to, formulating national health issues or to designing and implementing nation-wide public health programmes. Thus, the principal goal of the public health administration

remains largely un-served. The government needs to radically reorient its human resources priorities so as to equip its personnel to discharge their functions as service providers in the domain of public health. As a suggestion, the government could devise a scheme for greater monetary and promotional incentives for government personnel specialising in the public health discipline. In view of the undesirable tendency towards excessive clinical specialisation, a deliberate policy initiative needs to be taken by the central government to encourage post-graduate specialisation in the disciplines of 'Public Health' and 'Family Medicine'. In this context the recommendation in the National Health Policy-2002- that government should fix a norm for post-graduate seats in these neglected disciplines at 25% of the total number of seats in the medical institutions - is a relevant one. Fresh capacity for post-graduate studies should only be sanctioned to institutions in accordance with the norm. With increased intake in these disciplines, it can be expected that in the course of time, appreciation of public health issues will improve and experienced general practitioners will be able to offer effective 'first-line' treatment to their patients.

Health System Research

For operating a cost-effective national health system a permanent network of health system research institutions is required. Over the last two decades, Thailand has established an admirable network for carrying out rigorous health system research. An exclusive pool of health economists dedicated to this sector carry out the research. The span of the health system research in Thailand covers operational studies of the working of the system, as also the costs of the various alternatives. With the aid of such research the decision-making in the health sector becomes entirely evidence-based. The resultant policy and programme initiatives adopted in the field increases efficiency of the health system; also, increased availability of hard evidence empowers

the health sector to put across its proposals more effectively to the economic decision-makers located outside the health sector. Indonesia does not seem to have as systematic a health system research programme as Thailand, but it is still in a much better position than India. Indonesia does have a satisfactory system for collection of raw data relating to the health scenario, and thereby the health status of the country is relatively better known. They now need to proceed to carry out operational studies with varying parameters in order to gain insights for taking decisions relating to policy/programme initiatives. In India even the raw data collection relating to the health sector is very poor. Data collection is carried out merely through mechanical aggregation of reports from the lower formations, and this is never vetted or evaluated for accuracy. For example, for the last one and a half decades the reported incidence of malaria has hovered around 2 million cases per year. These are the cases with a positive blood sample test reported to the public health centre's. The recording of malaria cases by the system is entirely passive, and no attempt is made to estimate the number of malaria cases from amongst undiagnosed fever cases, where no blood sample was tested, but which were cured through conventional treatment. The public health centres in their reports, keep close to the previous year's figures, in order to avoid awkward questions about any unexplained rise or fall of the trend. Looking to these features, the figure reported is really a travesty of a meaningful public health statistic. Any person familiar with the Indian public health scene would know that the annual incidence of malaria is not less than 10 million cases. However, localised studies have shown to a much higher confidence level, that the incidence of *Plasmodium falciparum*, the more virulent variant of the disease, has risen to about 50% by year 1999. This is another serious development. In this backdrop, in the first instance, India has to build up a robust corpus of basic health statistics. Where diagnosis of a disease is not possible on a mass scale (e.g. TB, Malaria, Gastroenteritis, Diabetes), the public health system must be able to

obtain statistical estimates for its use. It also needs to be mentioned that currently the public health system does not even attempt to collect statistics relating to health economics. Independent researchers have only carried out some scattered and disparate studies. Looking to this central deficiency, there is an urgent need in the country to set up an institutional structure for health system research on the lines of the Health Systems Research Institute of Thailand. The results from the health system research will enable the health planners to realign policy more knowledgeably and to redesign the programmes to make them more cost-effective.

R&D in Health Sector

R&D expenditure is largely concentrated in the developed countries. In 1992 out of a total global expenditure of US\$ 55.8 billion for R&D, 93% was funded by developed countries and only 4% went into research in communicable diseases. R&D in the health sector in all the three countries under study here is miniscule. In India in 1998 the estimated expenditure on R&D in the health sector was 1.4% of the turnover in the sector. With the product patent law under TRIPS coming into force in 2005, all developing countries need to become aware of the changed circumstances. In the past, India made full use of its patent laws that allowed new process patents for reverse-engineered drugs that were still in the product patent domain in the developed world. As a result many therapeutic drugs, including those under a product patent domain in the western countries, became available through novel processes, to the patients in India. In this way the Indian pharmaceutical market offers a wide spectrum of drugs at a fraction of the cost in the west, making India one of lowest-cost health systems. Also, India through its drugs produced under its process patent law, was able to establish itself as a significant exporter of pharmaceutical products. With the new product patent regime coming into force the scope of producing new molecules/sera/vaccines will stand

considerably reduced. The new patent regime poses a challenge to Indonesia and Thailand even more than it does to India. In Indonesia very few drugs are manufactured indigenously from the basic raw material. Over 90% of the bulk drugs consumed in the country are imported. In Thailand 43% of the drugs consumed in the country are imported while 57% are indigenously manufactured (based on intermediate/bulk drugs). The high dependence on imported pharmaceutical drugs/sera/vaccines is a significant danger to the health security of the countries. The health systems of both Indonesia and Thailand faced a serious challenge as a result of the Southeast Asian financial crisis. Health expenditure was reduced and the quantum of goods and services that could be purchased was severely contracted as a result of crippling inflation. In Indonesia the quantity of drugs consumed in the post-crisis period saw a drop as the resources in dollar terms sharply contracted. In the resulting crisis situation the country could only make do by availing of substantial international funding. The Thai health system also underwent a serious setback in the post-crisis period. In the backdrop of the experience of Indonesia and Thailand, India should take adequate precautionary measures to retain its health security in the post-TRIPS patent situation. All the available legal space and flexibilities provided by the DOHA agreement should be utilised to compulsorily pre-empt patent rights over drugs in situations of public health emergencies, and also to provide drugs to other developing countries that do not have independent manufacturing capacity. The government would need to periodically review the newly patented drugs to assess whether they could ever be of use to our country in a public health emergency. This decision is required because a vast number of new patents are only incremental improvements, which are relevant only to an affluent economy. The screening of new patents by the government in advance enables the start of the 're-engineering process' well before any need for licensing it in a public health emergency arises. In other words, the country will always have a ready

shelf of 're-engineered' processes for patented drugs that can be compulsorily licensed at short notice on the occurrence of a public health emergency. It should be ensured that at least half the requirements of drugs/sera/vaccines for primary healthcare are indigenously manufactured. It needs to be highlighted that security in the health sector is an important component of broader national security.

The new patent regime from year 2005 also throws up rich possibilities for setting up India as a hub of R&D outsourcing. The process of releasing a new therapeutic drug in the market is a long drawn out and expensive one. The estimated cost of launching a new chemical entity in the developed world is US \$250-500, while the period of development is about 10 years. The cost of undertaking an identical research programme in India is only 20% of that in the developed countries. India also enjoys the advantage of a large pool of technical manpower possessing a high level of expertise and innovative talent. All these favourable elements can be capitalised to set up a major global R&D hub in India for conducting research in the medical sector.

National Rural Health Mission

The United Progressive Alliance Government has launched a National Rural Health Mission (NRHM) in the Budget for the year 2005-06. This has been projected as a novel conceptual innovation for the health sector. There has been much discussion in this monograph on the existing health system in the country, and in that backdrop it would appear apposite if the main features of the new mission, which is the hope for the future, are also discussed. At the outset, at a general level, a mention would be in order that the use of the expression 'mission' seems unusual. Normally this expression is applied to a short-term, time-bound plan with quantifiable goals and verifiable achievements. Provision of healthcare, like the provision of nutrition, is a never-ceasing

activity. Interventions in such an area are not suitable for the 'big bang' mission mode. The portion of the health sector activity in the Indian health system that can be considered appropriate for the mission mode is: creation of physical infrastructure in the health sector; or implementation of a disease control programme targeted at eradicating a disease, or a programme targeted at reducing the disease burden to a level when it can be managed by the regular public health administration. For a never-ceasing activity what is required is a stable and appropriately structured organisation, with flexible procedures and checks and balances, not more onerous than required to ensure a reasonable level of accountability in the utilisation of public funds. A desirable health system would be one, which when firmly established, would be largely self-driven, not requiring repeated and major interventions from outside agents. The approach of the NRHM seems to assume that all objectives in the Indian health sector, big or small, can be achieved in a short time period, thereby solving the public health problem once and forever.

The NRHM document covers almost all facets of the health sector, and beyond that, even the allied sectors, such as nutrition, sanitation, safe drinking water supply, etc. In one part it spells out detailed targets for strengthening the health sector – improving basic health indices; upgrading CHCs, providing essential drugs to the public health system, increasing medical/paramedical personnel to make availability compliant with norms, earmarking of a certain quantum of untied funds at the sub-centre level, etc. This is in line with some of the practical features contained in NHP-2002. In other parts the NRHM document takes an overview of the comprehensive health needs at, what can be called, a stratospheric altitude. The planned initiatives leave out almost no conceivable item. The document envisages the formulation of a village health plan by the village health panchayat samiti; similarly, at the next higher level it envisages the formulation of the district health plan. The conceived district health plan has a holistic coverage, including inter-sectoral

links with several allied sectors (providing nutrition, safe drinking water supply, sanitation, etc). It suggests the co-option of village health activists – Accredited Social Health Activists (ASHA) in the village level health network. The accredited social health activist is to be rewarded through performance-based, normative incentive payments for the various tasks performed (immunisation, construction of public toilets, referral services, etc), and by way of any other allowance that the panchayat samiti may choose to pay from their own resources. This health volunteer is supposed to serve as the link with the official public health machinery at the ANM level. The health services through the various service centres in the district are to be supervised by the district health mission. The conceptual plan also envisages a role for panchayati raj institutions in the decentralised health administration. The document suggests the abolition of the vertical field programmes and envisages their merger in the broad public health administration. It talks of regulation of medical practitioners, particularly informal rural practitioners (a euphemism for quacks). It recognises the need for codification of public health standards. It also envisages risk pooling and levying of progressively increasing user charges at public service centres, particularly hospitals. Non-official bodies - 'Rogi Kalyan Samitis' - are suggested for supervising the operation of public hospitals. The document encourages the launching of community-based health insurance schemes. At several places the document emphasises the need for an integrated plan for health, along with its associated determinants - water supply, sanitation, nutrition, etc. The importance placed on sanitation is to an extent that the mission document recommends increased resources for the Total Sanitation Campaign, a programme that comes within the purview of the Department of Rural Development. The foregoing details clearly show that the overview of the NRHM is as vast as the span of the Alma Ata declaration, promising nearly everything to every one. The plan can only be considered as one conceptually situated in the all-encompassing paradigm of 'Classical Universalism'.

The huge bank of objectives listed in the document appears more suitable for a plan with a half-century time frame rather than for the short tenure of a mission. Almost any idea that has been floated in the past is included in this mission document. The plan lists too many priority areas and in that dilutes the importance of all, such that eventually no priority is identifiable. Finally in the real world, some choices have to be made and some priorities adopted. Unless options are exercised the plan remains a virtual one, akin to the Alma Ata declaration. Many of the objectives in the document are somewhat in conflict with each other at their interface and cannot be implemented concurrently in the national health system. If all these wishes were to be fulfilled in a short timeframe, we would have to be an established super economic power like the USA with its immense financial and managerial capacity. In our struggling developing country we would necessarily have to trim our wish list and formulate a health system package commensurate with our implementation capacity. Some of the initiatives in the document that merit specific comments are discussed hereafter.

The idea of utilising health volunteers (ASHA) is not a new one. In the Janta Party government (1977–80), community health volunteers were introduced in the health system. In the malaria eradication programme, volunteers were associated with the blood sample testing procedure. Many other social sector programmes also envisage the co-option of voluntary workers - anganwadi workers under the Integrated Child Development Scheme; trained birth attendants; community mid wives; etc. However, the contribution of such volunteers must be realistically assessed. There is, of course, a growing group of NGOs who provide exemplary services out of a sense of commitment. However, their numbers are not such as to entrust to them the responsibilities of the entire health sector. Moreover, a person who is expected to come within the category of ASHA, would normally be a unemployed local lady. To expect a lady, who has failed to obtain gainful wage

employment in the formal economic system, to contribute significantly as a unpaid volunteer, would be an unrealistic hope. Local volunteers can no doubt contribute to supervision of services, and even occasionally to the actual delivery of services, but it would be too much to expect this on a continuing basis. This major initiative in the NRHM is much on the lines of the several schemes unsuccessfully tried out in Indonesia that relied excessively on community contribution in the form of finances and work-sharing. In a modern State the emphasis should, no doubt be on an increasing community participation in the matters that relate to needs of the citizenry. However, it cannot be expected that ordinary citizens will offer voluntary services even to the detriment of their own activities that are central to their lives at a subsistence level. For example, a financial contribution cannot be expected from a family below the poverty line; equally, free work-time can scarcely be contributed by those who have to do all their house work themselves as they cannot afford to purchase services of any type. In view of these factors, it is felt that excessive reliance on voluntary basic health workers would only prove a disappointment later on.

The document also envisages a high degree of planning at different levels. It talks of village health plans drawn up jointly by community representatives, the village level volunteer worker and the village level health department functionary. Then, the various village level health plans are assimilated into a district health plan. All this is desirable, but one needs to have a realistic idea of what to expect from these exercises. One should not expect unique plans for each village/district emerging out of the genius of the representatives from the decentralised level. The basic public health discipline would require that these decentralised plans should be shaped within the bounds of a macro-level technical plan. At the end of such an exercise it can be expected that at a certain level of detail the village health plans will differ, and the different district plans emerging from the assimilated

village health plans, will also differ. But, they would all be within the technical boundaries set out at the state level. The differences in the details of the plans would be vital in maximizing the satisfaction of the citizens' needs, but the decentralised planning exercise cannot be an unguided creative exercise. Equally important is the fact that the planning exercise would facilitate with considerable gain the decentralised implementation of the programmes under the supervision of local representatives. In this situation the decentralisation of the planning exercise within a certain set of technical guidelines, is highly desirable. With the gaining of experience, both the quality of the decentralised plan and the quality of supervision through the local-self-government entities, would significantly improve service outcomes. The trend towards strengthening of decentralised entities is, therefore, highly desirable. In the course of the implementation of the NRHM it would be pragmatic if some of the above-mentioned aspects, regarding decentralized planning, were kept in mind.

While making these comments on the NRHM, it must be clarified that this is not intended to criticise the effort. In fact, we would like to acknowledge that, perhaps for the first time since independence, a certain coalition of political forces has highlighted the social sector prominently on the political agenda. This is, indeed, gratifying. In the past, the health sector was given a nominal increase of a few percentage points in the annual budgetary allocations, and a paragraph or two in

the budget speech indicating some new and eye-catching initiative. There was no meeting ground between the requirements of the health sector and the budgetary response. The year-on-year changes in the health sector were of a proforma nature and the government's concern for this area of the socio-economy was only token. The CMP of the UPA government for the first time made a clear-cut commitment of increasing public health expenditure to 2-3% of the GDP by the end of their five-year term. This government's allocation of resources to the health sector, though still inadequate, has significantly improved. This, it may be recalled, is at a time when the target for reducing the fiscal deficit under the Fiscal Responsibility and Budget Management Act, has become a raging obsession. In the ambient atmosphere, the government's concern for the social sectors is so much more commendable. For the first time it can be said that the government has focused on the social sectors even at the cost of breaching one of the sacred tenets of neo-liberal economics. Perhaps, this is only an unavoidable response to the demands building up through the everyday dynamics of the polity. Nevertheless, the fact that the government has been responsive to community demands is a heartening sign. While in our view the NRHM may not be designed in the best possible fashion, and some comments have been offered in an earlier part of this monograph, the fact that government has at all undertaken such an exercise is good evidence of increased interest in this sector of governance.

VI. Conclusion

➤ One of the fundamental functions of the state is to secure 'Health' as a basic human right for its citizens in order to empower them to lead a productive and full life. The concept of what constitutes a reasonable claim to 'Right to Health' has changed over time in response to the changes in societal aspirations, as also changes in perception as to what is possible in the prevailing domestic circumstances. In the seventies, in a flush of community solidarity, the nations of the globe committed themselves to 'Health for All by the Year 2000 A.D.' An exuberant camaraderie swept the communities of the globe in those times, and the outcome was the Alma Ata declaration of 1978 that spoke of securing comprehensive primary healthcare for all. This declaration of intent, while being a statement of enormous empathy, unfortunately was not linked to an objective assessment of the financial and managerial capacities of the countries that were required to achieve it. At a conceptual level the Alma Ata declaration was set on the bedrock of 'Classical Universalism', but to most public health administrators it did not spell out an obvious direction for crafting implementable policies for the health sector, and for designing appropriate programmes/strategies in the field. The downsizing of our dreams for the health sector is not unique to India. Developing countries the world over, have had to scale down their expectations in order to better grapple with the problem in the real world. The three countries studied in this monograph are signatories to the Alma Ata declaration, and all should by now have achieved the standards envisaged for the health system. In earlier sections of this monograph an overview has been presented of the health scenario in the three countries as prevailing around the year 2000. Based on this overview, it would be futile to claim that these three countries are anywhere near

striking distance of the comprehensive healthcare envisaged in the rallying cry of 'Health for All by the Year 2000 A.D.' The overview of the health scenario of India and Indonesia reveals a rather dismal situation; while the scenario in Thailand, though not as comprehensively inadequate as in the other two countries, does not meet the minimal characteristics of an equitable and sustainable health system capable of delivering comprehensive healthcare.

The goal of 'Health for All' was a well-intentioned one and we would need to examine why it failed so completely. This was an idealistic goal not linked in any way with a work plan designed within the ground realities existing in the countries. Within the paradigm of 'Classical Universalism' the Alma Ata declaration promised primary healthcare for all in a time-bound manner. The expression 'primary healthcare' was as commodious and comprehensive as possible—including preventive, promotive and curative initiatives. The concept also envisaged linkages to the secondary and tertiary sectors. The burden of securing this basic right was enormous, whether provided through public sector, private sector or through a mix of these two. India never even got around to estimating the quantum of financial and material resources, the associated infrastructure and the required phasing of these inputs, for meeting the goal. In Indonesia in the initial years after the Alma Ata declaration the country strongly pushed towards the goal of 'Health for All', but from 1993 onwards, on account of resource inadequacy, the country adopted a 'zero growth' policy for the health sector. Consequently, the health sector went into a steep decline. Various experiments in community-based health initiatives were tried out in the subsequent period, but as pointed out earlier, without a minimal critical

mass of financial resources, they stood no chance of success. Thailand has made a considerable effort in harnessing financial resources in both the public and private health sectors. However, the health system is not efficiently designed. The health service delivery is through a variety of health security schemes with disparate structures and service packages. As a result, despite a considerable financial outlay in the sector, the shortcomings are still conspicuous. The access to health services is very uneven between the different economic sections of the country and healthcare costs have shown a sharply inflationary trend, raising fears that the existing structure of the health system is not sustainable. Thus, on both the counts - of equity and sustainability - the Thai health scene cannot even be said to be close to the Alma Ata goal of 'Health for All'.

- With the passage of time many countries came around to the conclusion that the goal of 'Health for All' under the Alma Ata declaration was, in fact, a chimera. Many of the political economies of the globe, regardless of their chosen ideology, found that there were so many pressing claims for the resources in the economy, that it became impossible to commit financial and manpower resources on the scale required exclusively for the health sector. Developed countries currently contribute an enormous share of the GDP to the funding of their health sectors. With high-tech medical care becoming costlier by the day, these countries began re-examining as to what can be said to constitute the basic right to health. In such countries there is an increasing search for alternative modes of financing of the health sector in an attempt to reduce the draw on the budget. As a result of the churning of ideas, developed countries are increasingly shifting towards increased reliance on private health security schemes.

In the developing countries the situation is entirely different. The principal obstacle in the health

system in these countries is lack of access to the health services for large sections of society on account of financial incapacity. As it is, in these countries private funding (principally, out-of-pocket funds) forms a dominant portion of the financial resources utilised in the health sector. The current quantum of private funding in the countries under study is: India-83%; Indonesia-74%; and Thailand-- 67%. In this scenario, at the macro level there does not appear to be any scope for enhanced private funding to the health sector in developing countries, an option that is readily available and has been adopted in the developed countries. However, for practical and organisational reasons both Indonesia and India have recognised the usefulness of a strategy of partial delivery of health services through private providers. In order to avail of schematic efficiencies both are introducing health security schemes with a variety of structural combinations. These will have to be backed with substantial state funding. Macro-economic planners in India, in their relentless pursuit of GDP growth, are instinctively averse to allocating resources to the social sectors. But, it is now clear that there is no escape from increasing resource allocations to the health sector over the rest of this decade, to a level double, if not more, than the current level of allocation. The capacity of the public health sector in terms of providing services is a critical determinant for improved health outcomes.

Conceptually, the financing pattern of Social Health Insurance (SHI) does envisage co-funding between private resources and state resources. However, in no variant case is it likely that the entire premium will be privately funded. In the various examples of SHI seen over the globe not one instance can be found where the SHI has been successful in a country coming in the low-income category (< US\$ 761 per annum). Most of these countries (average income > US\$ 761) have adopted the model of substantial private

finance. India, at its level of GDP, should never delude itself by expecting a significant quantum of private funding in its SHI initiative, at least in the early years of introduction of the scheme. More than 50% of the population would just not have the resources to meet the premium liability. For another section of 20% or so, while ex-facie some capacity to pay may exist, it would be difficult to convince them to pay a large amount to cover a risk for an eventuality that may not take place. Some commentators have argued that the annual private expenditure of Rs 1000 (approx.) incurred on the average per annum could go towards payment of the premium. Such an expectation is simplistic. In a large section of the population private health expenditure is almost entirely 'out-of-pocket'. This is incurred when the liquidity position of the family permits it, and that is often unrelated to the severity of the ailment. Just after the harvest it may be possible to incur considerable expenditure even for a relatively minor ailment, while during a lean period in the year even for emergency healthcare; a loan may have to be negotiated in the informal credit market. Because of this expenditure pattern, despite some private expenditure in some part of the year, as many as 24% of the patients fall into destitution as result of catastrophic illnesses. In many cases of severe illness the high expenditure incurred is financed through a crippling loan, and does not demonstrate ability to pay. In this background the capacity of an individual to comfortably pay a health insurance premium is much less than the average private health expenditure of Rs.1000 per annum. The whole purpose of an efficient health system is, firstly, to make medical services available to all sections of the citizenry; and secondly, to ensure that private costs of medical services do not drive the affected family into destitution. Hence, given the level of average per capita income in India and the other irreducible consumption needs, there seems to be no escape from the position that, at least in

the initial stages, the state would have to bear the larger part of the financial burden. With the acceleration of growth, which the neo-liberals confidently predict as the result of globalization, the capacity of the individual to contribute to the premium, should improve.

It would also appear that if developing countries, at the level of development of the three under study here, are to achieve universal health coverage, the package of assured health cover would have to be much more modest than envisaged in the Alma Ata declaration. The SHI now being planned would be consistent with the paradigm of 'New Universalism', which would attempt to provide an integrated, cost-effective health system with a public-private mix of service delivery, where the state would continue to contribute a substantial amount of financial resources. The need for sustained state funding must be viewed in the context of the fears expressed by many of the commentators on the process of globalisation—i.e. in the period of transition serious adverse effects are likely to be faced by the vulnerable sections of society. The adverse side effects of globalisation will have a direct impact on the access to basic needs—nutrition, health and education. **Thus, a view needs to be adopted that the state support for the social sector must be treated as an inseparable component of the reforms package during the transitional stages of globalisation. In other words, the development package to be adopted in the wake of globalisation would have to be a socio-economic reforms package with substantial funding for the social sector.**

- India needs to squarely face the fact that its funding of the health sector is grossly inadequate. The per capita public health expenditure in both India and Indonesia is of the same order (US\$ 4-5). Over the next decade India must ensure that its public health expenditure at

least equals the current per capita public health expenditure of Thailand (US\$ 40). This would be just enough to provide the minimum package of health services recommended by WHO's Commission on Macroeconomics and Health, which was estimated to cost US\$ 34 per capita. NHP-2002 has recommended increase in public health spending to 2% of GDP by year 2010 (equivalent to Rs 1005 per capita per year). This is broadly comparable to the commitment made in the Common Minimum Programme of the United Progressive Alliance government, of allocating 2-3% of GDP for the health sector by the end of the term of the present government. With the domestic contribution to the health sector rising to Rs. 1005 per capita, and factoring in additional foreign funding, a net per capita resource availability of approximately US\$ 40 can be adopted for planning purposes. Since the mark-up in outlay of the health sector in the first four years of the Tenth Plan has only been moderate, it is necessary to scale it up by at least 35% per year in the remaining years of the decade to be close to the target spelt out above.

- One striking paradox is that even though in many parts of the country the health system is extremely deficient, this shortcoming does not seem to feature as a serious electoral or political issue. This is despite the fact that it is manifest that an efficient health system is a vital contribution to community well being. The many shortcomings outlined in this monograph are seldom the subject of political discourse. In a healthy and mature polity one would expect that the basic needs of the community would normally come to be highlighted through the cut and thrust of the democratic polity. Yet, in the Indian states of Bihar and UP, where the need for an efficiently functioning health system is most acute, there is no public outcry over the issue. In this situation, are we to conclude that issues from the social sector, by their very nature, can never become

key issues for the national policy, which is based on hard-core economic elements?

On reflection, perhaps, it would appear that the socio - political dynamics in the country is much more complex, and our misunderstanding of the political-economy accounts for this seeming paradox. The various states of the country stand at different stages of development of the polity. In the states of Bihar and UP, the caste fault-lines, and the consequential imbalance in the power structure, is very marked. This was seen to result in the near total barring of large sections of society from controlling the levers of power in institutions of the state, and at an even more basic level, from accessing public goods and services generally provided by the state. The deprivation is so acute that the underprivileged section sees it as an affront to its basic human dignity. In these areas of the country the assertion of social identity in the power structure of the polity becomes the first step of the underprivileged towards empowerment. The increase in electoral clout of the middle castes—inter alia, by way of much increased representation in the legislatures/parliament - is a clear indicator of upward social mobility. The educated, urban middle class is often dismayed by the extent of strength exercised by these regional parties (middle castes) in the political process. They also express surprise that such social pressure groups seem oblivious to the material and economic betterment of their constituency. **However what they seem to miss out is that the communities constituting the lower end of the power pyramid are, in the first instance, emotionally driven to gain a foothold in the political power structure. As a first step, this is sufficient achievement for them.** If a member of the upper section of the social pyramid, for a moment transposes himself to a slot in the backward class, the rationale of the political priority adopted, would immediately

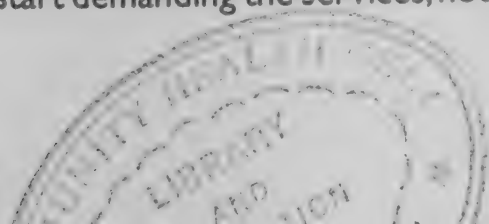
become apparent. Once the socially disadvantaged acquire the confidence that this share of the power structure is secured for good, they will no doubt turn to material issues and eventually, perhaps, even demand a functioning health system.

In the southern states of the country the political power structure has balanced out much more equitably. In Kerala, with a much higher level of education, no social section seems to be completely excluded from the power structure. In Tamil Nadu, the political philosophy of social empowerment of the under-privileged sections dates back to pre-independence days. In fact, over time the political power balance has swung completely, and today, if any one section appears to be excluded from the political power structure, it is the Brahmin community. In the remaining two southern states –Andhra Pradesh and Karnataka – while the forces of social empowerment cannot be said to be so strong, the power imbalance between different sections is not as marked as in the northern states. Thus, the southern states, having achieved some measure of social empowerment, now turn to other basic needs (nutrition, healthcare, education, etc) as their priority. It is marked that in the southern states the citizens expect a much better health system, particularly the public health services, and have the confidence to demand it. In the more underdeveloped parts of Bihar and UP there is no health system and yet there is no sense of material deprivation.

From this it would appear that the material issues relating to the social sectors do become significant in the political process, but only at a secondary stage, after establishing an equal social identity in the power structure. In fact, once the underprivileged section gets a taste of even the most rudimentary healthcare services, it is likely to start demanding the services, not merely at the

meager existing level, but at a level where it could reasonably be said to satisfy their basic human right to health. Once the citizenry recognizes that they can obtain a beneficial outcome from this sector, the demand for a share of it becomes a part of normal political power play. Increasingly the citizenry will demand an efficient health system, and using their political weight will also be able to obtain it in some measure. The political power that the citizens of the southern states have acquired to obtain better health services, would, in course of time seep to the citizenry of the other states, which at present are denied their basic human right to health.

- In several portions of the monograph the role of the private sector in the health system has been traversed. It has been noted that the public sector health service network is overstretched, and that it would be unreasonable to expect it to exclusively deliver health services to a population of over one billion. Considerable capacity of private health services does exist, particularly in the urban areas, and it would make sense to utilise them under a regulated system. In most countries social health insurance systems have a mixture of private and public service providers. **However, global experience has shown that unless private services are regulated under strict price and quality guidelines, the health system is unsustainable. Excessive and unbalanced reliance on private service providers makes the system a highly inflationary one. Private service providers make an extremely effective pressure group and can push the government towards a high-cost health system.** In Chile and Uruguay the experience of private health insurance, principally through private service providers, has brought to light serious market distortions. In the USA, despite a long experience of health insurance, rising health costs have far outpaced general inflation. Even in the UK, with an almost entirely state-funded



HIP-12-0
09228 P06

system, the use of private service providers has proved very inflationary.

With all this experience, any developing country starting a social health scheme would have to be wary of excessive privatisation. The services off-loaded to private providers must only be on the 'capitation fee' basis, and never on a 'fee-for-service' basis. Also, the arrangement, to be of value to the citizen, should be on a 'cashless' mechanism and not on 'indemnity' basis—only this will ensure that the family of the patient is not exposed to financial distress. Coverage must be over broad community pools and 'skimming' of handpicked sections of society should be carefully guarded against. It has been a common experience that once private service providers have come to dominate the system, it is very difficult to dislodge them, as they constitute a powerful lobby. Thus, for various reasons stated earlier, a regulated participation of private service providers is necessary, but the share of public health services should not be reduced to a miniscule level. In a conceptual framework, one can think of a goal of a mix of private and public service providers equally sharing the total load of services of the country. Considering that the public health expenditure is only 17%, and though the services provided are not strictly proportional to the expenditure, it is manifest that the public services are way short of the targeted 50% share. Also, because of problems of terrain and logistics, many remote areas of the country are unlikely to be served by a private social health insurance scheme, at least in the near future. To service these unmet needs, in any case, the public health services would have to increase their spread. **Thus by increasing the span of the public health services, and simultaneously launching social health insurance schemes, it is likely that over time the share of services from the two sectors would end up as approximately balanced. That would make for a safe and sustainable national health system.**

➤ As has been spelt out earlier, under the SHI it would be appropriate that the services be provided in roughly equal proportion by government and non-government entities. There are a large number of non-government entities that are already working in the social sector, or are otherwise capable of doing so. The first in any such list would be the category of local-self-government entities. The groundwork has been completed in the country for large-scale involvement of such bodies in decentralised development activities. Different tiers of the panchayati raj/municipal systems can manage health service delivery centres. Local-self-government functionaries in some states (e.g. Gujarat and Maharashtra), exercise some of the powers of management of service centres. The NHP-2002 also recommends that responsibilities and powers be devolved upon the lower tiers, and this be encouraged by offering incentive grants (over and above the normative grants), to decentralised entities undertaking responsibilities in the health sector. Several NGOs are known to be delivering exemplary services in the field of primary healthcare, even though their span of coverage is rather small. One estimate places the number of voluntary organisations working in the healthcare sector at over 7000. A NCAER Survey (1994) has indicated that 10.6% of the villages covered report the presence of some type of NGO in their area. This is another category of non-government service providers that need to be encouraged to venture out on a larger platform. In the course of time experienced NGOs can attempt to undertake the responsibilities up to the PHC level. There is also one viewpoint that health services can be delivered efficiently by professional management agents through a contract arrangement. Obviously, any scheme that may be devised cannot provide for lavish management fees for the agency engaged. However even this modality can be tried out to ascertain whether efficient management agencies can work on thin margins and still find it worth their while to undertake such activities. To sum

up, in the non-government category responsibility for providing health services can be entrusted to a variety of institutions—local-self-government entities; NGOs; contractual managers; etc—and it would be worthwhile to try out all these modalities within a framework of a set of basic guidelines.

- From time to time the government has been granting fiscal incentives to attract private investment to the health sector. In the Budget (2003-04) new private hospitals with more than 100 beds have been made eligible for tax exemption for capital investments under Section 10(23G) of the Income Tax Act. In other words, any infrastructure capital fund would be eligible for tax exemption in respect of any income by way of dividends, interest or long-term capital gains, from investments made in shares/debentures by way of long-term finance for such hospitals. Similarly, the premium paid under medical insurance schemes is also treated as exempt under the tax laws. It is felt that such schemes will have relatively minor impact and are not likely to contribute in a significant measure to the national goal of universal health coverage. To some extent some promoters will, no doubt, avail of the tax concessions to set up medium-sized hospitals. All available evidence seems to indicate that private health services are expensive and not cost-effective. Given that, the demand for private hospitals is not likely to grow beyond a point because of the limited capacity of the patient to pay. Tax concessions in favour of infrastructure companies only have meaning as an incentive if the project is viable. To state the obvious, if there is no profit, there can be no question of availing of a tax concession. Thus, it is assessed that this particular tax concession will, for the larger part, remain a dead letter on the statute.

While on the topic, it would be appropriate to examine on an *a priori* basis the propriety of granting tax exemption on premium paid on

health insurance cover. One cardinal principle of economic reforms is to abolish all exemptions, as they distort the market and result in a sub-optimal resource-allocation pattern. Under orthodox neo-liberal doctrine all subsidies are discouraged on these grounds. In this policy background, *prima facie*, it is not understood how fiscal concessions for private health insurance, are considered benign. Because of the high premium, the health insurance schemes will be limited to the economic elite. There is no possibility of the schemes growing into a product that can significantly contribute to the goal of universal health coverage. In these circumstances, the provision of tax exemptions to a high-income group can only be considered a flagrant violation of a key tenet of neo-liberal economics.

An assessment needs to be made as to whether fiscal incentives for the health sector are likely to cause structural damage to the general health system. Viewing these fiscal incentives in their totality, one can only describe them as token in nature; they are unlikely to attract the interest of many investors. Some commentators of the public health scene are critical of these incentives as it is apprehended that they will lead to the creation of a 'twin-track' health system in the country – one high-tech, high-cost one for the economic elite; and an underprovided one for the rest of the population. While we must guard against such a contingency, it appears unlikely that a 'twin-track' system will be created specifically as a result of the fiscal incentives. The potential of these incentives to attract individuals seems so limited that any impact on the national health scenario is likely to be only minor. Medium-sized hospitals and private health insurance schemes are expected to be so small in numbers and span of coverage, that they are unlikely to dominate the health system. However, a careful watch has to be maintained to ensure that incipient inflationary forces do not invade the health system unnoticed.

- For certain types of disease control programmes, the outreach can be extended beyond non-government organizations, to the entire community of medical practitioners. For example, the eradication/control programmes for Malaria, TB and Leprosy are particularly suited for broad-based service delivery : the standard treatment is not technically complex; the therapeutic drugs are not expensive; and these drugs are also disease-specific and cannot be diverted to any non-priority disease. The broadening of the national programmes for the above-mentioned diseases to include private practitioners, would not increase the scope for misuse of medical supplies. Simple record-keeping and inspection procedures can be prescribed to ensure that the recommended treatment regimen is observed, and there is no wanton waste of the drugs. **Beyond that, there is no need for controls, as only a sick person would use the drugs, and in that sense the use of drugs would be self-focused. The co-option of private practitioners in the implementation of the disease control programmes would increase the outreach of the system several-fold.**
- Several statutory regulatory bodies will have to be set up to maintain a smoothly running SHI. From the foregoing discussion it should be clear that the operation of the SHI would be an extremely complex one. Ordinary citizens would get lost in the system if the statutory regulatory authorities do not protect their interest. Some of the aspects that would have to be controlled would include: determination of standard premium; determination of capitation fees; defining the package of primary healthcare services; enlisting of private service providers; standardization of infrastructure of different levels of service providers; evaluation of quality of service provided to patients; grievance recording procedure; etc. Currently the limited control exercised over the health insurance entities is by the Insurance Regulation and Development Authority (IRDA), with health insurance as one of their operational divisions. While there may be a resistance to the creation of another statutory body for health insurance, at least the health division can be developed within the IRDA as a distinctly separate branch of insurance. Health insurance, unlike life insurance or other types of general insurance, requires monitoring of quality on a day-to-day basis. For a given pool of beneficiaries, illness would occur on a recurring basis and the system has to ensure that each episode of illness is adequately treated. Quality control over service delivery is a major and continuing activity. Also, reliable health statistics are scarce in India, and hence computation of risk and premium becomes extremely problematic. On the other hand, life insurance or other general insurance claims are activated on the occurrence of distinct events that are easily verifiable. Thus, servicing such insurance policies is simple. Also, mortality statistics are more robust and make it safer to base insurance schemes on such statistics. In this background a large body of experience will have to be built up relating to the different components of health insurance operations. Many of the statutory functions to be discharged would be far-removed from actuarial science – they would relate to clinical test protocols; treatment protocols, infrastructure standards for health service centres, etc. Whether these functions are carried out within IRDA through a large empowered division, or outside it through an independent statutory authority is a matter of detail. However, what is clear is that it cannot be treated as just another variety of general insurance, to be handled like, say, insurance cover for loss through theft.
- The R&D expenditure in the pharmaceutical sector is low in all the three countries studied. In India the R&D expenditure, aggregating both public and private sectors, was 1.4% of the

health sector turnover in the year 1998-99. NHP-2002 has recommended a quantum jump in this, with a target of public spending of 2% of health sector turnover by the year 2010. With the new product patent regime under TRIPS coming into force in India in 2005, the Indian pharmaceutical industry will be thrown into an unfamiliar work environment. In the past, Indian R&D was limited to process patents in respect of new molecules discovered elsewhere. The earlier law permitting process patents was a boon to a developing country like India. India developed an enviable array of indigenous generic drugs that were produced at very low cost. As a result India enjoyed a remarkably low-cost health system – for almost all the drugs in common use, the cost in USA is 30-200 times the Indian cost. The wide gap in drug prices in the two countries can be explained to an extent by the fact that Indian manufacturers avoided paying the patent fees; however, this is not a full explanation and the fact remains that after discounting for the avoidance of patent fees, the therapeutic drug prices in USA and other developed European countries are plainly exploitative.

It is necessary to note that in the changed patent regime from year 2005, India will have to guard itself against the inflationary trend of health costs that is widespread in the developed world. Already there are some ominous inflationary signals in the national health sector. The country does have a price control mechanism for therapeutic drugs through the Drug Price Control Order. However, in the currently prevailing atmosphere of liberalization in the country, the dominant mood in the commercial sector is averse to the widespread use of these powers. The Pharmaceutical Policy –2002 sets out the new norms for application of the Drugs Price Control Order to essential and important drugs required for the public health programmes. It is expected that the new policy will finally

reduce the coverage of price control to 25% of the drugs market. One cannot accurately predict how the new patent regime will impact upon domestic health sector costs. However, the government is required to stay alert and to impose a price control wherever required by the price trend, regardless of the scope of control defined in the extant policy.

The variety of drugs produced in the country creates a chaotic situation similar to that in the consumer goods sector. Currently, about 50-60,000 drugs / formulations are manufactured and marketed in the country. Scientific analysis justifies only a fraction of this number. Merely to generate market demand, unscrupulous manufacturers, assisted by a colluding regulatory administration, has created this unscientific array of pharmaceutical options by way of 'fixed-drug-combinations'. To arrest this inflationary trend in the health sector the government has to adopt a proactive policy for rational use of drugs. As a beginning, the public health system in the primary sector should, with immediate effect, limit its services to a list of essential drugs from outside the patent domain. Through CME programmes the private sector health service providers should also be guided towards the use of essential drugs only. The space available for domestic licensing of foreign patents (in the contingency of a national health emergency), as spelt out in the Doha declaration, should be exploited to the fullest. The current burden of communicable diseases – TB, Malaria and Gastroenteritis & Cholera – would automatically bring them within the ambit of a national health emergency. However, there are no significant drugs for these diseases within the patent regime, which could be useful to India; and, therefore, for the moment the question of domestically licensing such patents does not arise. **However, if new molecules/ vaccine/sera are developed for the age-old, communicable diseases, India can,**

with justification, compulsorily license the patent for domestic manufacture, as the country faces a continuing health emergency on account of these diseases.

While discussing drug research and patents, one point that stands out is that, for the common communicable diseases, which constitute a major portion of the disease burden, almost no research is being conducted in the developed world. In the period 1975-97, out of the 1223 medical patents registered, only 13 are related to tropical diseases, which could be of interest to a country like India from the public health point of view. The multinational pharmaceutical companies do not see an adequate return in the developing countries to make their research investment in communicable tropical diseases commercially viable. As has been declared in the consensus statement of the Global Health Forum- I of 2001: 'the move to globalize the protection of intellectual property rights is not politically sustainable without, at the same time, making the delivery of health technology more equitable'. Normally, improvement in technology is expected to result in lower costs; but, in the health sector, with the new technology, paradoxically, the outcome has been the reverse – higher technology has ramped up health sector costs. In this situation, a country like India must move independently and concentrate its research effort on the high burden diseases, for which no research product can be expected from the developed world. For a communicable disease like HIV-AIDS, which is not a very old disease, but which assumes great significance from the health and economic development point of view, indigenous research is necessary on the specific sub-type of virus (sub-type-C) which is the infection in most of the cases in the country. In conclusion, the drugs/vaccines that would prove useful to our country, will for the greater part, have to be developed indigenously.

India is in the fortunate position of being able to meet most of its requirements for the health sector from domestic production. In comparison, Indonesia is dependent to the extent of 90% on imported bulk drugs/intermediates/ finished drugs. This makes Indonesia's health system highly vulnerable – during the Southeast Asian financial crisis on account of the depreciation of the local currency, the per capita availability of drugs was reduced to a small fraction of the pre-crisis quantum. **As a norm, no country should permit a situation in which more than 50% of the drugs/sera/vaccine requirements have to be imported.** More importantly, the public goods required for the health sector - essential generic drugs, vaccines and sera - need to be indigenously manufactured in a large measure.

Another major gap in the knowledge base of the country is in respect of structural information relating to the health system. Basic data is very limited and of uncertain quality. For appropriate and cost-effective interventions in the health sector reliance has to be placed on robust data relating to the health system. The need for health system information is particularly acute when we are on the brink of introducing the SHI. The various components of the SHI – design of the healthcare package; standard premium; capitation rates; quality of services; etc.– will all have to be determined on the basis of robust data of the health system. Thailand provides a textbook model of an excellent institutional network for carrying out health system research. Health system research in Thailand was started some two decades ago, and the country has systematically consolidated a network for researching all aspects of the system – disease burden; access to healthcare; cost of services in private/public sectors; suitability of organizational structure; capacity available for different categories of service facilities; operational studies of field procedures;

etc. The data generated is of immense value in the course of policy formulation and project design. In Indonesia the health system research is, by and large, limited to data collection on incidence of disease and availability of different categories of services. The health system research activity, though only a small fraction of that in Thailand, is still much superior to that in India. In our country even basic data regarding burden of disease is not systematically collected and evaluated. As a result health policy formulation and project design is largely on the basis of intuitive assessment and not on hard evidence. Any country wanting to set right its health system would have to develop a corpus of researched data in order to be able to better understand the health system.

- For launching the SHI several decisions would have to be taken about the design of the field programmes. In the absence of any significant health system research, public health administrators would have a problem in arriving at evidence-based decisions. In order to generate some relevant data in a short span of time selected operational studies can be carried out to test the suitability of the various models. The studies could test out the variations in some of the combinations of parameters. These studies could, *inter alia*, cover: delivery cost of providing different packages of primary healthcare; optimum size of beneficiary pool attached to a service provider; different mixes of primary and secondary sector services in the packages; norms for enlisting NGOs/management agencies as service providers; etc. The design of the SHI scheme could be based on the data from the field trials – the results of the field trials would be of some use though they cannot replace a systematic database obtained through rigorous health system research.
- For a just and humane society the state must ensure for its citizens the basic human rights. These rights, even when limited to a minimum

span, would include: right to life, nutrition, health, education and opportunity for gainful employment. Given the current status of the health system it would be a considerable while before we attain the goal of universal health coverage, considered the minimum condition for enjoying the basic human right to health. It would take a couple of decades for the SHI to spread widely, and over that period the state's commitment would have to be resolute both in terms of funding and administrative oversight. In moving towards the goal of universal health coverage the health system would need to utilize service providers in both the private and public sectors. In order to ensure a cost-effective and sustainable health system the share of public service providers should always be maintained at a substantial level. The universal health coverage offered should be on an affordable scale covering primary healthcare. Substantial state funding should be continued till such time at least as India moves into the middle-income group of countries. No citizen should be denied this health coverage on account of financial incapacity. The category of non-government service providers should be widened to include local-self-government institutions, NGOs and even professional, 'for-profit' management entities. Health system research should be treated as a core activity in order to generate a database that could be used for further policy formulation and project design.

The economy has recorded a growth rate of over 6.5% GDP in the last two years, which is undoubtedly noteworthy. The diehard economic reformers attribute the higher average growth rate during the last decade-and-a-half entirely to the beneficial impact of globalization and liberalisation. Some even launch off from this position to a second-stage conclusion that the State must disengage itself from the social sectors. For them, the primeval entrepreneurial

forces of the free market are expected to release such immense productive energies that economic growth would be more than ample, and would in good measure trickle down to every strata of the economy. Discussion in the public arena in the recent past has been confined to 'economic growth', to the neglect of the concept of 'human development'. Even ardent reformers will agree that the concept of 'human development' is a much more commodious one that encompasses: equitable empowerment, ready access to basic human needs across the social spectrum and equal opportunity.

Generally, in public discourse no attention is paid to the assessment of the time horizon over which the narrow impact of 'economic growth' can reasonably be expected to mature into the concept of 'human development' for the broad cross-section of the community. National economic strategy can plan for reduced consumption in certain periods so that resources can be concentrated on the preferred production sectors in order to maximize future growth. But, such an option only arises after securing the requirements for subsistence survival for all. For over a quarter of the country's population, surviving in the present situation is a near impossible challenge. For this large section, the choice of swapping a part of today's consumption for tomorrow's accelerated economic growth is not a viable option. Subsistence needs, by their very nature, cannot be deferred. To state the obvious, the meeting of basic subsistence needs – nutrition, primary healthcare, elementary education, etc –

is the irreducible immediate need of the citizen and the minimal duty of the State, regardless of all else, including 'economic growth'.

In a hypothetical construct, within a democratic system, it is possible to envisage a popularly elected government that adopts a narrow policy that entirely ignores the subsistence needs of the citizenry. In the dynamics of a real-world democratic polity, this situation may be unlikely, but if it occurs as an aberration, it can only be concluded that democracy, as also the State, both have failed. Inequity between different sections will only be tolerated up to a certain point; after which the community will consider the development policy that causes this extreme inequity, a breach of faith. After all, no development policy can be devoid of its ethical genes. The dilemma of making a hard choice between 'equity' and 'growth' is never faced in the developed countries, as almost every one has access to subsistence levels of consumption. The current drive towards globalisation and economic reforms in our country would only be acceptable in the hearts of the citizenry when the basic human needs—nutrition, health and education - are provided in the system for all sections. In an overarching sense, a society can only be considered just and humane when the socio-economy, inter alia, strives to provide access to basic goods and services to all, excluding none on grounds of financial incapacity. And, when the State sets itself a mission-goal, the most modest one it can adopt commensurate with its position of pre-eminence, would be that of establishing a just and humane society.

References

- Administrative Staff College of India (Centre for Social Services) (1996): 'Feasibility Study on introducing Health Insurance Schemes in India'.
- Bennet, Sara & Viroj Tangcharoensathien (1993): 'Health Insurance and Private providers: A study of the Civil Servants' Medical Benefit Scheme in Bangkok, Thailand' – International Journal of Health Planning and Management (Vol. 8).
- Bhat, Ramesh (1996): 'Regulation of Private Health Sector in India'. International Journal of Health Planning and Management.
- Carrin, Guy (2002): 'Social Health Insurance in Developing Countries: A Continuing Challenge'.
- Census – 2001. Registrar General of India (Website).
- Javid A. Chowdhury, (2003): 'Health Care Financing in Indonesia in a Period of Decentralization.' World Health Organisation.
- Javid A. Chowdhury, (2003): 'Modes of Health Service Delivery in India: Public-Private Mix'. World Health Organisation.
- Javid A. Chowdhury, (2003): 'Towards Universal Health Coverage in Thailand'. World Health Organisation.
- Donaldson, Davy et al. (1999): 'Health Financing in Thailand: Summary Review and Proposed Reforms'. Health System Research Institute, Thailand.
- Duggal, R. (2000): 'The Private Health Sector in India: Nature, Trends and a Critique'. Voluntary Health Association of India.
- Ellis, Randal P, Moneer Alam & Indarani Gupta (2000) 'Health Care in India – Prognosis and Prospectus'. Economic and Political Weekly.
- Ferreiro, Alejandro (1999): 'An overview of the Chilean Private Health Insurance System and some useful lessons for the current Indian debate.'
- Ford Foundation (1991): 'Health Economics, Health Financing and the Health Needs of Poor Women and Children in India' (Programme Paper).
- Gani, Ascobat 'Financing Delivery of Primary Health Care in Rural Indonesia'. University of Indonesia.
- Gumber, Anil (2001): 'Extending Health Insurance to the Poor: Some Experiences from Sewa Scheme'. Journal of National Institute of Health and Family Welfare.
- International Institute of Population Sciences and ORC Macro (2000): 'National Family Health Survey (NFHS-2), 1998-99: India'.
- International Labour Organisation (2001): 'The Self-Employed Women's Association's Integrated Insurance Scheme, India'.
- Kumar, Mukesh and Joby George (2000): 'Rural Health Insurance: A Care-India Experience in Tribal Areas of Jharkhand'. Centre for Enquiry into Health and Allied Themes.
- Lieberman, S. et al. (2001): 'Government Health Expenditure in Indonesia through December, 2000: An Update'. World Bank (East Asia & Pacific Region).
- London School of Hygiene and Tropical Medicine, Department of Public Health and Policy (1998): 'Exempting the Poor: A review and evaluation of the Low Income Card Scheme in Thailand'.
- Mahal, Ajay (2001): 'Assessing Private Health Insurance in India: Potential Impacts and Regulatory Issues.' National Council of Applied Economic Growth.
- Mahal, Ajay (2000): 'Equity implications of Private Health Insurance'. National Council of Applied Economic Growth.
- Mahal, Ajay et al (2000): 'Who Benefits from the Public Sector Health Spending in India?' National Council of Applied Economic Growth.
- Marzolf, James R. (2002): 'The Indonesian Reform – An Analysis of Obstacles and Constraints to Growth' (Draft). World Bank.
- Medici et al (1997): 'Managed Care and Managed Competition in Latin America and the Caribbean'.

- Mills, Anne (1996) : 'Achieving Universal Coverage in Health System: Strategies and Pre-requisites'; Health System Research Institute, Thailand.
- Mills, Anne (2000) : 'The response of providers to capitation payment: a case-study from Thailand' – Health Policy.
- Ministry of Health (Directorate of Community Participation) (1997): 'Dana Sehat and JPKM (Community-Based Health Insurance)'.
- Ministry of Health and Social Welfare, Republic of Indonesia (2000): 'Community Health Centres in Indonesia'.
- Ministry of Health and Social Welfare, Republic of Indonesia : 'Posyandu (Integrated Service Post)'.
- Ministry of Health Directorate of Selected Community Health Development , Republic of Indonesia: 'History of Community Health Services in Indonesia'.
- Ministry of Health, Republic of Indonesia (1989): 'Community Health Financing in Indonesia'.
- Ministry of Health, Republic of Indonesia (1999): 'Health Development Plan Towards Healthy Indonesia –2010'.
- Ministry of Health, Republic of Indonesia: 'Primary Health Care in Indonesia'.
- Ministry of Health, Republic of Indonesia: 'History of Community Health Services in Indonesia'.
- Ministry of Public Health, Government of Thailand (2002) : 'Thailand Health Profile : 1999-2000.'
- Misra, Rajiv, Rachel Chatterjee & Sujatha Rao (2003) 'India Health Indicators' Oxford University Press.
- Nandraj, Sunil & R.Duggal (1996) 'Physical Standards in the Private Health Sector'. Radical Journal of Health.
- National Health Policy –2002. Department of Health, Ministry of Health and Family Welfare, Government of India.
- National Population Policy –2000.(Appen. iv).
- National Sample Survey Organisation (1998): 'Morbidity and Treatment of Ailments'.
- National Sample Survey Organisation (2001): 'Nutritional Intake in India'. Department of Statistics,
- National Seminar on Development of Health Insurance in India : 'Current Status and Future Directions'.
- National Institute of Health and Family Welfare.
- Naylor, David, Prabhat Jha, John Woods and Abusaleh Shariff: 'A Fine Balance: Some Options for Private and Public Health Care in Urban India'. The Human Development Network. World Bank.
- Noor, G.Rizali: 'JPKM/Managed Care –An Overview'.
- Peters, David H,et al (2002): 'Better Health Systems for India's Poor – Findings, Analysis and Options'. World Bank.
- Peters, David H. et al (2002): 'Better Health Systems for India's Poor – Findings, Analysis and Options'. World Bank.
- Planning Commission (2002): 'Health Sector Financing'. (Sub-group report for the Xth Five Year Plan.
- Pramualratana, Phromporn & Suwit Wibulpolprasert (2002)(Eds.): 'Health Insurance Systems in Thailand'.
- Ranson, Michel Kent (2002): 'Reduction of Catastrophic Healthcare Expenditures by a Community-based Health Insurance Scheme In Gujarat: Current Experiences and Challenges'. Bulletin of the World Health Organisation – The International Journal of Public Health Research.
- Saadah, Fadia, et al (1999): 'Indonesian Health Expenditures during the Crisis: Have they been Protected?' World Bank (East Asia and Pacific Region).
- Thabrany, Hisbullah (2000): 'Private Health Sector in Indonesia: Opportunity and Progresses'. University of Indonesia.
- Thabrany, Hisbullah : 'Health Care Financing in Indonesia: A Review of Two Decades'.
- Thabrany, Hisbullah: 'The Development of Pre-paid Health Care in Indonesia'. University of Indonesia.

Thangcharoensathien, Viroj et al.(2000) : 'Health impact of rapid economic changes in Thailand' - Social Science and Medicine.

Visaria, Pravin & Anil Gumber (1995): 'Indian Policy and Financing Strategies for Strengthening Primary Healthcare Services'World Bank.

Voluntary Health Association of India (1997)' Report of the Independent Commission on Health In India'.

Website-Country Health Profile – Thailand: <http://intranet/entryhealth/Thailand/thaistatistics.htm>

World Bank (1993): 'World Development Report: Investing in Health'.

World Bank (1993): 'World Development Report: Investing in Health'.

World Bank (2000). 'Private Health Insurance and Public Health Goals in India –Report on a National Seminar'.

World Bank (2000): 'Health Strategy in a Post-Crisis Decentralizing Indonesia'.

World Bank (2000): 'World Development Report'.

World Bank (2001): 'India: Raising the Sights - Better Health Systems for India's Poor'.

World Development Indicators (2000).

World Health Organisation (1999): 'World Health Report'.

World Health Organisation (2000): 'World Health Report'.

World Health Organisation (2000): 'Approach to the initiation of Health Systems Reform; HSRI's Forum – 2000. Final Project Report.

World Health Organisation (2001). Report of the Commission on Macroeconomics and Health - 'Macroeconomics and Health: Investing in Health for Economic Development'.

World Health Organisation (2002): 'Forum on Public Health Sector Reform'. Final Project Report.

World Health Organisation (Country Office – Thailand) (2002) : 'Decentralization Action Plan Development' –Final Project Report.

World Health Organisation (Country Office – Thailand) (2001) : 'Evaluation of reforming payment mechanism to hospital and primary care network under the public assistance programme in six provinces' –Final Project Report.

World Health Organisation: 'Equity in Access to Public Health'- Report and Documentation of the Technical Discussions held in conjunction with the 37th Meeting of the CCPDM.

World Health Organisation: 'Country Cooperation Strategy – Indonesia'.

World Health Organisation: 'Health Situation in South-East Asia – Basic Indicators 2000'.

List of Abbreviations

ANM	Auxiliary Nurse-Midwife	MMR	Maternal Mortality Rate
ARTI	Annual Rate of Tuberculous Infection	MNC	Multi-national Company
ASHA	Accredited Social Health Activists	MOHFW	Ministry of Health and Family Welfare
BPL	Below Poverty Line	MPW	Multi-Purpose Worker
CBHI	Central Bureau of Health Intelligence	NCAER	National Council for Applied Economic Research
CBR	Crude Birth Rate	NFHS -2	National Family Health Survey -2
CDR	Crude Death Rate	MWS	Medical Welfare Scheme
CGHS	Central Government Health Scheme	NGO	Non-Governmental Organisation
CHC	Community Health Centre	NHP-2002	National Health Policy- 2002
CME	Continuing Medical Education	NRHM	National Rural Health Mission
CMP	Common Minimum Programme	NSSO	National Sample Survey Organisation
CSMBS	Civil Servant Medical Benefit Scheme	OPD	Out-patient Department
CVD	Cardio-vascular Disease	OT	Operation Theatre
DOTS	Directly Observed Treatment, Short-course	PHC	Primary Health Centre
ESIS	Employees' State Insurance Scheme	SC	Sub-Centre
GDP	Gross Domestic Product	SHI	Social Health Insurance
GNP	Gross National Product	SSS	(Unorganised Sector's) Social Security Scheme
HMO	Health Management Organisation	TRIPS	Trade-Related Aspects of Intellectual Property Rights
IMR	Infant Mortality Rate	UHS	Universal Health Insurance Scheme
IRDA	Insurance Development Regulatory Authority	VHCS	Voluntary Health Card Scheme
LE	Life Expectancy	WHO	World Health Organisation
MCH	Maternal and Child Health		

The Independent Commission on Development and Health in India

The Independent Commission on Development and Health in India (ICDHI), formerly known as The Independent Commission on Health in India (ICHI), was formed in 1995, facilitated by Voluntary Health Association of India. The commission, comprising of distinguished people from the development and health sectors, aims at assessing the development and health situation of the country through policy research and analysis, in-depth surveys, focus group discussions, public hearings, round table conferences with developmental workers, policy makers and people, particularly disadvantaged community at large. By means of participatory process, the Commission seeks to identify the maladies impeding the development and progress of the country and come out with clearly defined solution to the problems identified. The Commission works closely with the Prime Minister's Office, Ministry of Health & Family Welfare and Planning Commission within the government, and reputed Research organizations, Non-government organizations, Panchayati Raj Institutions at the grassroots as well as other relevant forums. The first report of the Commission was released by the Prime Minister and was presented to the President. The report was discussed in the Parliamentary forum. ICDHI's constant endeavour has been to facilitate the process of need based and people-centric sustainable development.

ISBN- 81-88973-93-9
Rs. 55.00

ISBN: 81-88973-93-9



**The Independent
Commission on
Development and
Health in India**